LEICESTERSHIRE PARTNERSHIP TRUST WIDE CQC ACTION PLAN 2017

CQC ACTION PLAN - In response to the CQC Comprehensive inspection of LPT services

Overarching reference code	Provider Report 'Requirement action'	Directorate	Action Reference	Core Service Report	Core Service 'Requirement Action'	Please describe clearly the action/s you are going to take to meet the regulation and what you intend to achieve	How are you going to ensure that the improvements have been made and are sustainable? What measures are going to be put in place to check this?	What resources (if any) are needed to implement the change(s) and are these resources available?	Insert the date the action AND evidence will be provided	How will people who use the service(s) be affected by you not meeting this regulation until this date?	Manager responsible for delivering the action?	Comments/ Remedial Actions	Directorate RAG Rating	Committee RAG Rating	CompAss RAG Rating	Group responsible for delivering the actions	Expected CompAss (earliest)
1.	The trust had not ensured that where appropriate, patients were involved in care planning and that this is recorded.	Corporate	1	LP NHS Trust Report	The trust had not ensured that where appropriate, patients were involved in care planning and that this is recorded.	Core standards of record keeping and care planning to be embedded across all Directorates; standard 5 refers to patient and carer involvement. (Intention to achieve - all health care professionals are aware of the Trust's core standards of record keeping and care planning and the importance of patient involvement). Escalation process for record keeping and care planning to be in place and overseen as necessary by Lead Nurses. Escalation process incorporates the need for regular monitoring of standards and subsequent processes to be followed for improvements to be achieved. (Intention to achieve - individual practitioners / teams and services that require support to improve are known and strategies are implemented to make the improvement). Record keeping and care planning training provided within each Directoriate to be reviewed and amended to include the core standards, examples within practice and associated expectations of good practice. (Intention to achieve - all health care professionals are aware of the Trust's core standards of record keeping and care planning and the importance of patient involvement). Explore the opportunity for engagement with patient involvement groups to consider patient expectations for care planning. (Intention to achieve - patient voice is considered to help address areas and strategies of improvement)	Confirmation of review of record keeping and care planning training, evidence of inclusion on care planning and record keeping core standards included within the lesson plans. Monthly monitoring of the core standards for record keeping and care planning to be commenced. Directorate reporting to Clinical Effectiveness Group each quarter; evidencing areas of good practice and areas for development inclusive of improvement methods that are being applied. Compliance training reports.	Administration support to enable monitoring processes. Centralised system to be developed for a trust wide system (e.g. share point) to enhance the reporting processes. Training sessions and facilitators to deliver sessions.	September 2017 (This will allow for each Directorate to have reported once or twice to CEG) Evidence to include; Directorate CEG reports via Governance Leads / Revision lessons plans to incude core standards	Poor patient experience due to the potential that care provided is not cognisant with patient values, beliefs, choice and expectations.	Head of Professional Practice and Education				w	Clinical Effectiveness Group	Oct-17
		AMH/LD	1.1	Long stay/rehabilitation mental health wards for working age adults	Record keeping was disorganised. Staff used a mixture of paper and electronic records which were not easy to follow. We found loose papers in records. There were problems with access to the electronic system owing to ongoing building works. There was no evidence of patient involvement recorded in some of the notes.	1. Senior Matron to complete local spot check regarding patient involvement to establish baseline. Results to be feedback to staff in newsletters/staff meetings and addressed individually in clinical supervision. 2. Identify duplication of paper and electronic records and ensure staff complete electronic rather than paper records to support better organisation of paper records and move to a paper light system 3. Senior Matron to review record keeping audit to include question re the organisation of paper notes 4. Staff to be reminded of their responsibility on night shifts to file paper and place in appropriate sections into patients clinical folders. (Building work has now been completed. New HD Inpatient Service has moved across to Stewart House site.)	1 . Results to be fedback to nursing staff through clinical governance route including meetings, newsletters and addressed individually in clinical supervision. 2. Care Planning audit to be completed monthly, results generated electronically by ward and fedback in clinical governance meetings, staff newsletter and addressed in individual staff supervision where required.	1. Time will be needed for continued monitoring and to ascertain what paper records are in use . 2. Time for spot check of patient folders to evidence completion of night task and information is in the correct and appropriate sections. 3. Time to monitor access to electronic records.	30/04/17	Poor organisation of notes could lead to patient information being missed and potentially impact on care delivery .	Head of Nursing AMH/LD Clinical Director AMH/LD						
		AMH/LD	1.2	Long stay/rehabilitation mental health wards for working age adults	Local audits were not completed regularly. Team managers could not be assured of local performance around record keeping, care planning and patient involvement.	1. Care planning audit to be undertaken monthly via on-line system by designated staff and results fedback as below. 2. Spot check regarding care planning and patient involvement. Results to be fedback in clinical governance meeting/staff newsletter/staff meetings and individual clinical supervision where required.	1. Feedback from monthly on line system to be generated and discussed in clinical governance and local management meetings 2. repeat of spot checks when baseline position established for improvement.	1. Senior matron, Team leaders and clinical auditor all require time for completion, feedback and review of audit. 2. Allocated time for supervision is planned and recorded.	30/04/17	Lack of patient involvement limits patients choices regarding their care; results in their views not being considered and consequently patients not feeling engaged with care process or the professionals delivering their care, and potentially a worse outcome for patients	Head of Nursing AMH/LD Clinical Director AMH/LD						
2	The trust had not ensured that care plans were holistic and personalised.	Corporate	2	LP NHS Trust Report	The trust had not ensured that care plans were holistic and personalised.	Refer to reference code 1 and action reference 1.	Refer to reference code 1 and action reference 1.	Refer to reference code 1 and action reference 1.	Refer to reference code 1 and action reference 1.	Refer to reference code 1 and action reference 1.	Refer to reference code 1 and action reference 1.		W				
		CHS	2.1	Community-based mental health services for older people	The care plans did not detail the care and treatment the patient needed to manage risks appropriately for their health and safety.			1. Staff time to be released to engage in and undertake development actions on behalf of the 12 month project group 2. Patient and Carer involvement. 3. Resource to change RIO functionality where needed and identified to improve the system for clincians and patients in regards to collaborative recovery focused care planning	March 2017 - March 2018	Care plans will not reflect patient need and mitigate risk resulting in the potential for harm and not achieving self defined recovery	HoS (AMH & MHWSOP) Community Managers (AMH & MHWSOP) Nurse Leads (AMH and MHWSOP)	actions split below as per discussion with HD following June compass however actions in column h do not match those in column I - HD to advise.	W		w		
			2.1.1			1. Form a 12 month Collaborative and Recovery Focused Care Planning Improvement project Group with AMH and MHSOP Community and Inpatient Services as both are utlising RIO electronically to develop a collaborative and recovery focused care planning approach	1. Evidence of the Collaborative and Recovery Focused Improvement Group meeting and workstreams established to realise improvements through the minutes of the meeting over the 12 month period	See 2.1	March 2017 - March 2018		See 2.1				w		
			2.1.2			2. Involve Clinicians, Patients, Carers and RIO Team in the improvement.	2. Evidence of membership of patients and carers being consulted and involved in changes through minutes and focus groups	See 2.1	March 2017 - March 2018		See 2.1				w		
			2.1.3			3. Establish a baseline Care Planning snapshot to review quality of care plans building on CQC evidence, including evidence of or lack of patient/carer involvement, evidence or lack of collaborative recovery focused planning, evidence of care and treatment including the management of risk.	3. Evidence of baseline snapshot of community and inpatient services snapshot with recommendations for changes.		March 2017 - March 2018		See 2.1				w		
			2.1.4			4. Analyse the current functionality of RIO and gain clinician and patient feedback on their current experience of care and risk planning whilst making recommendations for electronic improvements on RIO that are clinician and patient focused	4. Evidence of a written and update Care Planning Guidance that is patient and carer collaborative and recovery focused.		March 2017 - March 2018		See 2.1				w	Clinical Effectiveness Group	Apr-18
			2.1.5			5. Audit against NICE CG 136 Guideline	5. Evidence of improvements and changes in practice by undertaking Care Planning snapshots at 6 and 12 months which will demonstrate patients and carers are being fully involved in formulating personal care plans and this is recorded, copies of plans are given to patients, that these are focusd into recovery and contain evidence of care and treatment including agreed risk management contigency planning (WRAP)		March 2017 - March 2018		See 2.1				w		
			2.1.6			6. Build on and further develop the Recovery Focused philosophy in care planning across all ages in MH services and draw from best practice approaches to develop collaborative and recovery focused care planning electronically.	6. As a contingency a paper based version of the care plan will be agreed with patient/carer before the electonic solution has been reviewed and recommendations for changes made		March 2017 - March 2018		See 2.1				w		
			2.1.7			7. Develop printable Care Plan solution that can be written and signed with the patient.	7. Access to interpreters to translate care plans where english is not the first language.		March 2017 - March 2018		See 2.1				w		
			2.1.8			8. Develop guidance on Collaborative and Recovery Care Planning for clincians, Patients and Carer's.			March 2017 - March 2018		See 2.1				w		
	The trust had not ensured that care plans were holistic and personalised.	FYPC	2.2.	Specialist community mental health services for children and young people.	Risk assessments and care plans were not always in place or up dated whilst young people were waiting for treatment.	See 2.2.1 - 2.2.6 below	See 2.2.1 - 2.2.6 below	See 2.2.1 - 2.2.6 below	See 2.2.1 - 2.2.6 below			Actions split below to allow RAG as per Compass 30.05.17.			w		
			2.2.1			To review the risk assessment for all patients on CAMHS waiting lists.	To introduce a system of spot checks of CAMHS waiting lists.	CAMHS Clinical Team.	End April 2017								
			2.2.2			To implement a system to review all patients on CAMHS waiting lists every 6 months using a standardised caseload review tool which includes risk assessment and care plans.	To introduce a system of spot checks of CAMHS waiting lists.	CAMHS Recovery & Improvement Team.	End June 2017			~~amber advised by Adam as being rechecked for completeness - email 31.05.17~~ Red as per June meeting. Back to amber July (04.08).					
			2.2.3			SystmOne Configuration will support easy identification of clinician caseload.	CAMHS clinical caseloads will be easily visible on SystmOne.	SystmOne team	End July 2017			~~amber advised by Adam as being rechecked for completeness - email 31.05.17~~ Red as per June meeting. Back to amber August meeting					
			2.2.4			Clinical Supervision to include direct review of clinical record including risk assessment as per policy. Supervisors should have access to an adequate data set including details on risk assessments and care plans to enable a focus on quality.	Nothing identified	CAMHS Clinical Supervisors.	End of September 2017			~~amber advised by Adam as being rechecked for completeness - email 31.05.17 Red as per June meeting.~~ Back to w July (04.08).	w				

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			2.2.5			To update the CAMHS SystmOne care planning template to include patient/carer's involvement and recovery focus.	To be included in the FYPC Record Keeping Audit.	Lead Nurse	End July 2017			~~amber advised by Adam as being rechecked for completeness - email 31.05.17~~ Red as per June meeting. Amber as per Bal CEG report					
			2.2.6			To implement consistent use of SystmOne care planning template in all CAMHS teams.	To be included in the FYPC Record Keeping Audit.	Lead Nurse	End July 2017			~~amber advised by Adam as being rechecked for completeness - email 31.05.17~~ Red as per June meeting. Amber as per Bal CEG report					
3	The trust did not ensure that patients' care and treatment needs were assessed by people with the required level of skills and knowledge, specifically in relation to psychological input.	Corporate	3	LP NHS Trust Report	The trust did not ensure that patients' care and treatment needs were assessed by people with the required level of skills and knowledge, specifically in relation to psychological input.	See actions 3.1 and 3.2	See actions 3.1 and 3.2	See actions 3.1 and 3.2	See actions 3.1 and 3.2	See actions 3.1 and 3.2	See actions 3.1 and 3.2		w	w	w	AMHLD Divisional Assurance Group	~~01/10/2017~~ Nov 17
		AMH/LD	3.1	Acute wards for adults of working age and PICU	The trust had not ensured that patients could access psychological input, in accordance with National Institute for Health and Care Excellence (NICE) guidelines.	Continue with recruitment to additional posts.	Posts recruited to	Interview panel time, HR support, banding panel time	August 2017	Until team fully complimented will rely on single psychologist and staff trained to low level psychological inputs	Service Manager and BMHU Psychologist						
		AMH/LD	3.2	Community based mental health services for adults of working age	The trust had not ensured that waiting times for access to psychology were kept to a minimum.	See actions 3.2.1 - 3.2.4	See actions 3.2.1 - 3.2.4	See actions 3.2.1 - 3.2.4	See actions 3.2.1 - 3.2.4	Patients who are in treatment or waiting for treatment will remain open to the relevant CMHT or Medical Outpatients.	Service Manager		w	w	w		
			3.2.1			Monitor waiting times compliance, implementation of PTL process across clinical psychology service.	Monthly reporting at Directorate Business and Performance meeting with analysis of initial results.	PTL meetings require admin support and clinical and managerial attendance.	April 2017 PTL meeting notes and BAP meeting notes.								
			3.2.2			Integrate the Psychological Therapies review with the Community re-design work streams.	Reporting at AMH community Redesign group meetings.	Redesign steering group, clinical and managerial time.	April 2017 Redesign meeting notes.								
			3.2.3			~~Enable psychological therapy advice and clinical supervision and training of CMHT staff.~~ Review current Referral Management Protocol for CMHT Clinical Psychology and integrate into CMHT Operational Policy to ensure that all patients continue to be monitored for risk and deterioration whilst awaiting a clinical psychology assessment/start of treatment.	~~COMMS to community service and action plan~~ SOP.	~~Clinical time which will initially adversely impact on waiting times for clinical psychology with longer term benefits. Baseline mapping to allow evaluation of impact on clinical psychology of training and supervision for CMHTs~~	~~Baseline mapping and development of training tool April 2017. Rollout of training and supervision May 2017. Evaluation of benefits Sept 2017.~~ November 2017			Action amended as per compass meeting 30.05.,17					
			3.2.4			Clinical Psychology facilitated supervision sessions to be embedded as a routine clinical supervision structure within each CMHT	SOP. Evidence of sessions planned and attendance. Plan for monitoring risk and deterioration		November 2017			Action created as per compass meeting 30.05.17					
4	The trust did not ensure the privacy and dignity of patients was protected due to lack of privacy curtains or not using the curtains when patients received treatment.	Corporate	4	LP NHS Trust Report	The trust did not ensure the privacy and dignity of patients was protected due to lack of privacy curtains or not using the curtains when patients received treatment.	Senior Matrons / Lead Nurse within AMH / LD to carry out an assessment of all areas where privacy curtains should be or are used to ensure they are in place and used during care and treatment. Findings to be shared with relevant staff and expectations for identified areas of improvement to be stated, alongside a date for review where necessary. Collective findings and overview of actions to be reported to Patient Experience Group.	Complete assessment of all areas and share findings with relevant staff / service managers for action. Evidence of actions taken to be reported to the quality monitoring group. Review of areas that required improvements measures to be taken to be completed and report to be provided to Patient Experience Group.	Allocation time by Senior Matrons and Lead Nurses.	June 2017 Findings of assessments of all areas and recommendations for improvements to be reported to Patient Experience Group. September 2017 review report.	Patients privacy and dignity will not be maintained resulting in poor patient experience.	Head of Professional Practice and Education					Patient Carer Experience Group (Chair Bal Johal)	Jul-17
		AMH/LD	4.1	Acute wards for adults of working age and PICU	Shower rooms on one ward did not have shower curtains for the privacy and dignity of patients.	Shower curtains are now in place	N/A	N/A	N/A	N/A	N/A						
		AMH/LD	4.2	Community based mental health services for adults of working age	Lack of privacy curtains or not using the curtains when patients received treatment.	1) All CMHT's who use clinics to provide treatments to complete initial spot check that rooms are fit for purpose and in relation to privacy and dignity. 2) Posters to be displayed in all clinic areas informing patients of their right for privacy and dignity.	1) Initial inspection of all rooms to ensure they are fit for purpose. 2) 6 monthly inspections to ensure rooms remain fit for purpose. 3) Regular reminders in business meetings. 4) 6 monthly check that posters remain in situ.	1) Staff time. 2) Estates input if curtains need fitting/replacing. 3) Staff with IT skills to design posters.	1) Spot check all bases by the end of March 2017. 2) Posters up by end of March 2017.	Treatment provided in areas with minimal privacy.	Michelle Churchard Smith Head of Nursing AMH/LD						
5	The trust did not ensure that staff adhered to the Mental Capacity Act Code of Practice and to the principles of the Act specifically in regards to formal capacity, best interest decisions and Mental Capacity Act when completing Do Not Attempt Cardio-Respiratory Resuscitation forms.	Corporate	5	LP NHS Trust Report	The trust did not ensure that staff adhered to the Mental Capacity Act Code of Practice and to the principles of the Act specifically in regards to formal capacity, best interest decisions and Mental Capacity Act when completing Do Not Attempt Cardio-Respiratory Resuscitation forms.	Overarching MCA Improvement Strategy devised, brief overview includes the following; MCA training will be reviewed with the intention to ensure that staff are provided with the knowledge in a manner that can influence and improve their practice. MCA principles to be mentioned within all clinically relevant training with the intention to ensure that staff recognise the relevance and practical application of MCA to consent to treatment, DNAR etc. Self regulation toolkits to be amended to include MCA compliance, with the intention of enabling teams / service to report on their MCA compliance and take ownership of the improvement of application required. Directorates to devise a process for monitoring MCA compliance within services and report through the Safeguarding Committee. Escalation process to be devised and approved by the Safeguarding Committee to provide a clear route of support for practitioners making decisions in complex or challenging situations. Governance structure for reporting of MCA compliance to be strengthened. To enable practitioners to access clinical support visits from a MCA expert to enhance individual and team understanding. Model of safeguarding supervision to be devised and presented to Safeguarding Committee, which is reflective of the level of expertise within practice; with the intention of supporting practitioners in practice to reflect on complex or situations that they found challenging.	Evidence of training review and revised training programme; lesson plan. Training compliance rate for targeted individulas; evaluation of training. Revised governance structures and evidence of reporting processes. Model of supervision and escalation processes available. Self regulation outcomes and montioring processes from Directorates. Review of MCA consent to admission audit tool and repeat audit.	Focused MCA lead to support practitioners within their area of practice to make improvements. Administration support for monitoring processes within the Directorates. Allocated time to revise / devise processes/ policies etc. Release staff to access specific training (band 7 and MCA champions initially). Trainers time.	Improvements will be commenced from March 2017; details of specific dates according to MCA improvement strategy.	Patient care will not be in accordance with the required legal framework. Patients indiviudal beliefs, choices and values will not underpin the care delivered.	Head of Professional Practice and Education	Purple by directorate and blue by committee in report rec'd between sept and oct compass. Can't add as blue without completion of actions below - 09.10.17 - CDH	w	w	w		
		FYPC & CHS	5.1	Community End of Life Care	Do Not Attempt Cardio-Respiratory Resuscitation' (DNACPR) decisions were not always completed fully in accordance with the trust's own policy and the legal framework of the Mental Capacity Act 2005. There were inconsistencies in the completion of forms which included lack of mental capacity assessments for those deemed to lack capacity, lack of information regarding the discussions held with patients and/or their families and not discussing the DNACPR with the patient, even though it stated they had capacity. DNACPR decisions and discussions were not always clearly recorded in the patient's medical records.	See 5.1.1 - 5.1.4	See 5.1.1 - 5.1.4	See 5.1.1 - 5.1.4	See 5.1.1 - 5.1.4	Patients wishes regarding their own DNAR may not be appropriate or understood by the family	See 5.1.1 - 5.1.4		w	w	w		
		FYPC & CHS	5.1.1			FYPC & CHS Consideration of the adoption of the RESPECT DNAR/CPR form for adults and children to be reviewed by the LPT Resus Committee.	Streamlining of documentation across the trust.	FYPC Palliative Care Lead, CHS Nurse Consultant.	End December 2017		Adam McKeown&Caroline Barclay						
		CHS	5.1.2			Content of EOL skills days to be reviewed to include completion of the form, the difficult conversations and advanced communication around DNAR including the development of bite size training.	EOL skills days are run in association with LOROS and the development of DNAR bite size training will support targeted learning which will support the champions in their cascade learning		October 2017		David Leeson						
		CHS	5.1.3			DNAR re-audit to take place in May 2017 to include MCA and best interest decisions.	Audit results will be shared with the EOL Steering Group for oversight and action.		August 2017		Caroline Barclay						
		CHS	5.1.4			Patient/Family information leaflet regarding DNAR to be considered by the EOL Steering Group.	Information will ensure that patients and family are aware of the process and the meaning of completing a DNAR form and will aid the understanding around further difficult conversations especially in the last year of life.		July 2017		Sara Lowe						

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		CHS	5.2	Community Health Inpatient Services	Staff did not always understand the requirements of the MCA 2005 in relation to their roles and responsibilities.	Lead identified within community hospital service line to develop the actions required to be taken to implement sustainable improvement with staff across all community hospital wards as part of the trust wide improvement plan	The action plan will be developed with ward staff and will be a dynamic document utilising a number of approaches to support sustained knowledge and understanding. A full action plan will be in place by the end of April 2017 and actions will be reviewed monthly at the service line service development group. Progress will be monitored via corporate groups.	Staff will need to be released to ensure they undertake the appropriate training as per their banding	Full action plan devised, individual actions identified in points below.	Patients at risk of receiving care or treatment which is not of benefit to their care	Jane Howden						

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		CHS	5.2.1	Community Health Inpatient Services		Service line governance meeting agenda will include MCA/DOL's item for discussion at every meeting.			April 2017								
		CHS	5.2.2	Community Health Inpatient Services		Quarterly report on the MCA and DoL's submissions - completion by ward.	Discussion item at Governance meeting		June 2017								
		CHS	5.2.3	Community Health Inpatient Services		Inpatient DoL's applications that have not been approved to be followed up on a weekly basis by wards contacting DoL's team		Devise audi tool and complete monthly documentation audit	August 2017								
		CHS	5.2.4	Community Health Inpatient Services		Directorate and service line risks are identified and accurately recorded on safeguard - T3 risk to be entered for each ward. T2 risk for the community hosjpital wards to be entered on the live risk register			May 2017								
		CHS	5.2.5	Community Health Inpatient Services		Services will be aware of their compliance with MCA principles and DoL's applications through self-assessment and will audit against practice.	Audit resulsts will be discussed at monthly service line governance meeting.		June 2017								
		CHS	5.2.6	Community Health Inpatient Services		MCA training to build on practitioner knowledge whilst enabling the developmnent of care culture that will support the philosophical aim of the legislation. Staff questionnaire to be distributed to all registered nurses via the matron team	Completed questionnaires returned and results ready for discussion.		May 2017								
		CHS	5.2.7	Community Health Inpatient Services		MCA training to build on practitioner knowledge whilst enabling the developmnent of care culture that will support the philosophical aim of the legislation. Break out training sessions for ward champions.	Attendance list		June 2017								
		CHS	5.2.8	Community Health Inpatient Services		MCA training to build on practitioner knowledge whilst enabling the developmnent of care culture that will support the philosophical aim of the legislation. Nominated ward champions will attend the quarterly Champions training events	Attendance list		18th May 2017								
		CHS	5.2.9	Community Health Inpatient Services		MCA training to build on practitioner knowledge whilst enabling the developmnent of care culture that will support the philosophical aim of the legislation. Additional training to be arranged for ANP staff.	Attendance list		July 2017							Safeguarding Committee	~~01/01/2018~~ Feb 18
		CHS	5.2.10	Community Health Inpatient Services		MCA training programme is reflective of expected level of expeterise and the decisions needed to be reached - Education team to devise Band 7 and Champion training.	Attendance list		July 2017								
		CHS	5.2.11	Community Health Inpatient Services		MCA training programme is reflective of expected level of expeterise and the decisions needed to be reached - Each ward will have teaching sessions devoted to; Consent, MCA, Best interest, DoL's, Safeguarding.	Attendance list		Sept 2017								
		CHS	5.2.12	Community Health Inpatient Services		On patient admission and within each care plan devised on System One, Consent to treatment and/or Best interest decisions are documented throughout.	Documentation audit results		Feb 2018			Implementation commences May 17					
		CHS	5.2.13	Community Health Inpatient Services		Quarterly supervision session at SING meeting, 1:1 or group ward supervision to include case discussion and 'safe' opportunities to explore and consider responses to challenges encountered when balancing professional accountability, patient autonomy and health care provison.	Minutes of meetings, supervision records.		June 2017								
		CHS	5.3	Community-based mental health services for older people	Formal capacity assessments and best interest's decisions were not properly recorded within the care records.	see 5.0	see 5.0	see 5.0	see 5.0	see 5.0	see 5.0	also see CHS MCA/Dols imp plan					
		AMH/LD	5.4	Long stay/rehabilitation mental health wards for working age adults	Staff had received training in Mental Capacity Act however capacity assessments were unclear and staff were confused about implementing DoL standards. From a review of records we found several references to DoLS applications but the paperwork was incomplete and records did not show updates on progress of the applications.	Registered Nurse information given regarding MCA and DOLs at RN days (24th and 31st Jan 2017 for The Willows staff nurses and 21st and 28th February 2017 for Stewart House staff nurses.) 1. A Spot check to be undertaken by Senior Matron of Mental Capacity Assessments completed by both medical and nursing staff to obtain baseline correlation of content of MCA assessment forms with the guidance. 2. Ensure that all staff understand their roles and responsibilities in relation to MCA assessments and DoLs by re-distribution of the flow chart in respect of mental capacity assessments and the flow chart in respect of DoLs 3. To ensure MCA training is completed on u-learn for compliance.	1. Results from spot checks by senior matron to be fedback back through local clinical governance systems and actioned for improvement by nursing and/or medical staff as determined by the outcomes of the spot checks. 2. For the unit Matrons to ensure via staff meetings, newsletter and clinical supervision that staff are familiar with the MCA and DoLs flow charts and understand their roles and responsibilities process. 3. Monthly review of training matrix to be undertaken by the Team managers, Ward Matrons and Team leaders. 4. Non clinical staff to review patient notes on a monthly basis for updates of DoLs applications and feed results back to ward matrons to action with primary nurses. 5. Senior Matron to request quarterly feedback on DoLs applications for rehab from designated contact to support the update process.	1. Time for Matron and supervisors to ensure staffs understanding of processes in place through supervision. 2. Time for the supervisor to address and review documentation during supervision sessions. 3. For Team Manager and matrons to monitor compliance of training records. 4. Time for senior Matron to obtain and feedback information relating to DoLs	31/03/2017	Lack of understanding of the MCA, DoLs and best interest decision making processes could result in patients being kept in hospital in contravention of their right to leave; decisions being made on their behalf without following due process in relation to admission, treatment, accommodation, finances and future plans for their care	Clinical Directors, Team Manager, Senior Matron, Ward Matrons and Team leaders					
		CHS	5.5	Community health services for adults	Insufficient numbers of nursing staff (substantive and bank nurses) had completed mandatory training in topics that were key to their role. This included the Mental Capacity Act 2005, fire safety and safeguarding.	1. All mandatory e-learning in each hub to achieve 80% by 30 June and 85% by 30 Sept. Delivery is to be incorprated into daily care planning arrangements for teams to build capacity to complete. 2. All face to face training to be booked in advance to maintain 85% or higher compliance with in date training. Delivery is to be incorprated into daily care planning arrangements for teams to build capacity to complete. 3. Three yearly Core Mandatory training in each hub to be sustained at 85% or higher. Delivery is to be incorprated into daily care planning arrangements for teams to build capacity to complete. 4. Staff on periods of extended absence will have all training booked as part of return to work plan to ensure compliance with mandatory training as soon as possible on return to work. Delivery is to be incorprated into daily care planning arrangements for teams to build capacity to complete.	Monitoring and oversight will sit with the Community Governance Group and will be reported via the new hub reporting processes. Reporting will be via the workforce sitreps.	Actions 1 - 3: Staffing capacity to ensure that training is undertaken Action 4: None identified	1. - 30th Sept 2017 2. - 30th Sept 2017 3. - 30th Sept 2017 4. - 30th Sept 2017	Patients may receive care and treatment from a workforce without the appropriate skills to deliver effective care	Matrons, Clinical Leads and DN's					
		AMH/LD	5.6	Wards for people with learning disabilities.	Staff were assessing for capacity to consent to admission after admission had taken place and after they had made a DoLS application. Capacity assessments were not decision specific.	Staff to be advised of the need to review capacity consent when undertaking decisions with patients.	To be included in the audit of patient records undertaken yearly.	Resources in pace for the audit	September 2017	Actions will be implemented to ensure that this is commenced prior to the audit date.	Service Manager						
		CHS	5.7	Wards for older people with mental health problems.	Not all patients had recorded assessments of capacity	The Service Line Action plan will be reflected in the Trust Wide MCA Improvement Plan overseen by the Safeguarding Committee.	See 5.0	See 5.0	July 2017 advised by Committee paper June 17	See 5.0	See 5.0	also see CHS MCA/Dols imp plan					

LEICESTERSHIRE PARTNERSHIP TRUST WIDE CQC ACTION PLAN 2017

CQC ACTION PLAN - In response to the CQC Comprehensive inspection of LPT services

Overarching reference code	Provider Report 'Requirement action'	Directorate	Action Reference	Core Service Report	Core Service 'Requirement Action'	Please describe clearly the action/s you are going to take to meet the regulation and what you intend to achieve	How are you going to ensure that the improvements have been made and are sustainable? What measures are going to be put in place to check this?	What resources (if any) are needed to implement the change(s) and are these resources available?	Insert the date the action AND evidence will be provided	How will people who use the service(s) be affected by you not meeting this regulation until this date?	Manager responsible for delivering the action?	Comments/ Remedial Actions	Directorate RAG Rating	Committee RAG Rating	CompAss RAG Rating	Group responsible for delivering the actions	Expected CompAss (earliest)
		CHS	5.8	Wards for older people with mental health problems.	There was no documentation of best interest decision making.	The Service Line Action plan will be reflected in the Trust Wide MCA Improvement Plan overseen by the Safeguarding Committee.	See 5.0	See 5.0	July 2017 advised by Committee paper June 18	See 5.0	See 5.0	also see CHS MCA/Dols imp plan					
		CHS	5.9	Community Health Inpatient Services	Patients' capacity was not always suitably assessed.	Lead identified within community hospital service line to develop the actions required to be taken to implement sustainable improvement with staff across all community hospital wards	The action plan will be developed with ward staff and will be a dynamic document utilising a number of approaches to support sustained knowledge and understanding. A full action plan will be in place by the end of April 2017 and actions will be reviewed monthly at the service line service development group. Progress will be monitored via corporate groups.	Staff will need to be released to ensure they undertake the appropriate training as per their banding	Full action plan devised and detailed under points 5.2.1 to 5.2.13 as per CompAss May 2017	Patients at risk of receiving care or treatment which is not of benefit to their care	Jane Howden	also see CHS MCA/Dols imp plan					
		CHS	5.10	Community Health Inpatient Services	Staff did not always complete a Deprivation of Liberty Safeguard for patients who had sensor cushions despite being aware they should complete one as they were restricing the movement of these patients.	Lead identified within community hospital service line to develop the actions required to be taken to implement sustainable improvement with staff across all community hospital wards.	The action plan will be developed with ward staff and will be a dynamic document utilising a number of approaches to support sustained knowledge and understanding. A full action plan will be in place by the end of April 2017 and actions will be reviewed monthly at the service line service development group. Progress will be monitored via corporate groups.	Staff will need to be released to ensure they undertake the appropriate training as per their banding	Full action plan devised and detailed under points 5.2.1 to 5.2.13 as per CompAss May 2017	Patients at risk of receiving care or treatment which is not of benefit to their care	Jane Howden	also see CHS MCA/Dols imp plan					
		CHS	5.11	Wards for older people with mental health problems.	Some DoLS applications were completed prior to assessment.	The Service Line Action plan will be reflected in the Trust Wide MCA Improvement Plan overseen by the Safeguarding Committee.	See 5.0	See 5.0	See 5.0	See 5.0	See 5.0	also see CHS MCA/Dols imp plan					
		CHS	5.12	Wards for older people with mental health problems.	Assessments were not always decision specific.	The Service Line Action plan will be reflected in the Trust Wide MCA Improvement Plan overseen by the Safeguarding Committee.	See 5.0	See 5.0	See 5.0	See 5.0	See 5.0	also see CHS MCA/Dols imp plan					
		AMH/LD	5.13	Long stay/rehabilitation mental health wards for working age adults	In one record we looked at the record said the patient had capacity but a T2 (consent to treatment) form had been completed which indicates no capacity. Capacity assessments were incomplete and records showed confusion over which decisions required a best interest assessment. Staff were also unsure when asked.	1. Continue to monitor and action the results of the MHA audit (includes review of capacity assessment forms). 2. Weekly checks of the T2 and T3 forms. 3. Reminder to be sent to staff regarding circumstances when a best interest decision is required. 4. Admission checklist to be amended to include specific reference to check of T2s/T3s and C6s at the point of admission.	1. Matrons to review monthly audit results and address any issues regarding process or understanding with individual primary nurses 2. Matrons to spot check (or delegate) to ensure weekend duties are being carried out. 3. Matrons to monitor training matrix for compliance with MCA training and address non compliance with individual staff.	1. Time for matrons to review audit results .2. for a member of the management team to be present in both meetings to be assured that information is correct and reflective of consent. 3.Time for matrons to review training matrix.	31/03/2017	See 5.4	See 5.4					
6	The trust had not addressed the identified safety concerns in the health-based place of safety.	Corporate	6	LP NHS Trust Report	The trust had not addressed the identified safety concerns in the health-based place of safety.	See 6.1 and 6.2	See 6.1 and 6.2	See 6.1 and 6.2	See 6.1 and 6.2	See 6.1 and 6.2	Helen Perfect Head of Service ICL/AMHLD					AMHLD Divisional Assurance Group	Jul-17
		AMH/LD	6.1	Mental health crisis services and health based places of safety.	The health-based place of safety at the Bradgate unit did not meet guidance, access arrangements were unsafe, doors were not anti-barricade and patients were unable to lie down.	Refurbishments are being carried out to the health based place of safety which will include key improvements such as separate entrances for children, young people and adults, two single assessment rooms with ensuite toilet and shower facilities, line-of-sight observations with vision panels/ CCTV coverage, welfare facilities for patients including clocks, kitchen point, music points and clinical equipment including defibrillator and medicine fridge. The improvements will also include staff emergency escape routes, appropriate environmental standards for windows, doors and ceilings - (including anti-barricade doors and deadlocks), and an office space with suitable computer/ IT facilities for AMHPs, police and staff.	The works are scheduled to take place from 30th January 2017. It is a 16 week build programme which is underway from 6th February 2017 with a week scheduled for snagging and a deep clean from 29th May 2017 Opening of the refurbished, all age health based place of safety is due on the week commencing 05/06/2017	In 2016 Leicestershire Partnership Trust were successful in securing a capital bid from NHS England for £500,000 to refurbish the existing health based place of safety. The improvements to the unit were agreed upon by referring to Royal College of Psychiatrists Standards for Health Based Place of Safety, Responses to Leicestershire Partnership NHS Trust CQC Report, Health Building Note Standards, Mental Health Crisis Care Concordat Place of Safety Review March 2015 and Guidance for Commissioners – Mental Health Act	Opening of the refurbished, all age health based place of safety is due on the week commencing 05/06/2017	While the works are taking place on the current health based place of safety, a temporary arrangement has been made for Griffin ward at the Herschel Prins Centre to be used for this purpose. The affect on patients will be that this too is not all age complaint, however the doors are anti-barricade, access has been improved with designated parking for police and there are beds for patients to lie down.	Team Manager (Bed Management)					
		AMH/LD	6.2	Mental health crisis services and health based places of safety.	We found out of date medication and equipment located in the health-based place of safety.	The out of date medication and equipment has been removed from the health based place of safety. The newly refurbished health based place of safety will have a medication fridge, medication cupboard and emergency equipment	The works are scheduled to take place from 30th January 2017. It is a 16 week build programme which is underway from 6th February 2017 with a week scheduled for snagging and a deep clean from 29th May 2017 Opening of the refurbished, all age health based place of safety is due on the week commencing 05/06/2017	In 2016 Leicestershire Partnership Trust were successful in securing a capital bid from NHS England for £500,000 to refurbish the existing health based place of safety. The improvements to the unit were agreed upon by referring to Royal College of Psychiatrists Standards for Health Based Place of Safety, responses to Leicestershire Partnership NHS Trust CQC Report, Health Building Note Standards,Mental Health Crisis Care Concordat Place of Safety Review March 2015 and Guidance for Commissioners – Mental Health Act.	Opening of the refurbished, all age health based place of safety is due on the week commencing 05/06/2017	While the works are taking place on the current health based place of safety, a temporary arrangement has been made for Griffin ward at the Herschel Prins Centre to be used for this purpose. These facilities currently have a locked medicine trolley, locked medicine fridge, emergency grab bag, emergency drug box and access to a defibrillator in the reception area. The grab bag is checked and sealed on a daily basis by staff .	Team Manager (Bed Management)					
7	The trust did not ensure that all mixed sex accommodation met guidance and promoted safety and dignity.	Corporate	7	LP NHS Trust Report	The trust did not ensure that all mixed sex accommodation met guidance and promoted safety and dignity.	See 7.1, 7.2, 7.3	See 7.1, 7.2, 7.3	See 7.1, 7.2, 7.3	See 7.1, 7.2, 7.3	See 7.1, 7.2, 7.3	Michelle Churchard Smith Head of Nursing AMH/LD		W	w	w		
		AMH/LD	7.1	Acute wards for adults of working age and PICU	The trust admitted males to female areas. - The trust must ensure that it complies with DoH guidance in relation to mixed sex accommodation.	Review incidents where males or females were admitted to a bedroom in a corridor of the opposite sex and the length of time this occurred for. Agree with the AMH/LD Senior Management Team and then Trust Board the practice standards we will implement if the need arises in the future. Develop criteria for admission of male/female patients to female/male area of ward, including additional safeguards.	Established risk based process for admission and agreement regarding contingencies. Monitoring via incident reporting and quality checks.	Completed by bed management team.	30/04/17 report to AMH/LD SMT	No immediate risk	Team Manager - Bed Management	Purple not supported by PCEG in July (3rd part of action still to be completed but LB hopes will come to compass Aug/Sept)				Patient Carer Experience Group	Aug-17
		AMH/LD	7.2	Long stay/rehabilitation mental health wards for working age adults	Men using the laundry had to pass women's bathroom and bedrooms. The 30 bed unit at Stewart House was mixed sex and there were no doors to lock between the male and female sections.	Review scope at Stewart House regarding same sex accommodation to ascertain if changes can be made to secure compliance	1. Senior Matron to review if internal doors are required to meet the requirements or alternative options are available to ensure single sex accommodation.	1. Time for senior Matron to review.	28/04/2017	No immediate risk	Team Managers and Senior Matron and Head of Nursing						
		AMH/LD	7.3	Wards for people with learning disabilities.	The short stay services did not comply with the mixed sex accommodation guidelines. There were not separate areas for female bedrooms. There were not separate male and female bathrooms and toilets.	The Short Breaks Management and Clinical Team will review all possibilities to achieve same sex accommodation standards however the homes are run on a philosophy of a' family home environment' and has not previously been viewed as to be non-compliant. Consider options for compliance with redevlopment of the Short Breaks service	Options to be discussed with Short Breaks Project group and Commissioners. Identify appropriate bathroom facilities appropriate to gender and ensure these are clearly marked	Potential requirement for change of use of buildings/ physical change to environments. Needs to be considered by project group and Trust regarding change of use.	July 2017	Interim arrangements will be put in place to ensure Gender specific bathroom facilities are available.	Team Matron, Service Manager and Head of Service (redesign)						
8	The trust did not ensure that all ligature risks were identified on the ligature risk audit and had not done all that is reasonably practicable to mitigate any such risks.	Corporate	8	LP NHS Trust Report	The trust did not ensure that all ligature risks were identified on the ligature risk audit and had not done all that is reasonably practicable to mitigate any such risks.	See 8.0.1 and 8.0.2 below	Action plan feedback to Service Operational group. Task and finish group reporting into DAG	Matron, Estates, Health and Safety reps time. Capital funds.	30/ 04 /17	Ligature risks will continue to be managed as detailed on individual risk assessments	Head of Service ICL		w	w	w	Patient Safety Group	Apr-18
			8.0.1			Review all ligature risk audits to ensure all risks identified and an action plan to address issues is in place. For Community MH bases: Ligature risk assessments are completed for all bases where patients are seen.	As above	As above	30/ 04 /17	As above	Head of Service ICL						
			8.0.2			Establish AMHLD Ligature works task and finish group to review all outstanding ligature risk and removal programmes and agree schedule for management.	As above	As above	30/ 04 /17	As above	Head of Service ICL						
		AMH/LD	8.1	Acute wards for adults of working age and PICU	Wards continued to have ligature risks, including door handles, soap and towel dispensers and window closers.	See action 8. Additional action re doors and door handles: Programme of works to replace doors and door handles	Programme of work overseen by BMHU service manager	Capital funds	Work scheduled to start May 2017 for 12 weeks. Advised June meeting - start of works delayed by 4 weeks	all individuals are risk assessed and placed in the appropriate environment for them with, if required, increased observations to mitigate any risks.	Service Manager						
		AMH/LD	8.2	Acute wards for adults of working age and PICU	The trust had hydraulic beds in use. These beds posed a risk of ligature and barricade for patients.	Work commences in March 2017 for the fitting of 40 fixed beds across the BMHU with plans to reduce the number of hydraulic beds to 3 per ward by the end of March 2018 to ensure patients with mobility or disability needs are able to be supported appropriately. The use of the hydraulic beds will continue to be risk assessed and monitored for individual patients to maintain patient safety.	Audit of number of hydraulic beds still within the BMHU	Capital funds to purchase and fit fixed beds	March 2018	All individuals are risk assessed and placed in the appropriate environment for them with if required increased observations to mitigate any risks.	Senior Matrons						

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9	The trust had not ensured that blind spots on ward areas were managed to ensure staff can easily observe patients.	Corporate	9	LP NHS Trust Report	The trust had not ensured that blind spots on ward areas were managed to ensure staff can easily observe patients.		See 9.1 & 9.2	See 9.1 & 9.2	See 9.1 & 9.2	See 9.1 & 9.2	Head of Service ICL		W	w	w	Patient Safety Group	May-17
		AMH/LD	9.1	Acute wards for adults of working age and PICU	Wards had areas where staff could not easily observe patients.	Review of environmental risk assessments and plans established to address blind spots.	The environment of the current wards cannot be changed to alleviate blind spots, all staff are aware of the blind spots and each patient is risk assessed and appropriate plans in place to manage risks.	Structural changes to the wards affected. Resources not available at this time.	April 2017	Staffing and placement of staff to reflect on going risk posed by blind spots where relevant	Inpatient Lead						
		AMH/LD	9.2 (.1 - 6 and .8,9&10)	Long stay/rehabilitation mental health wards for working age adults	The environment in some areas was very poor, particularly in Stewart House. There was a lack of storage at Stewart House; the utility/laundry room was used to store cleaning equipment. Clinic room temperatures were very hot, although one thermometer was above a radiator so would not give an accurate reading. The clinic room on ~~Arran~~ should read Skye ward at Stewart house was not appropriate; the room was a bedroom and still had a toilet in. There was no fridge to keep medicines cool when required. The occupational therapy kitchen at The Willows was not fit for purpose and poorly equipped. The ovens were old and the dials were not visible and cupboards were broken. There were no vision panels on patient bedrooms. There was a blind spot in the seclusion room on Maple ward at The Willows which meant staff could not easily observe patients. NB 1. Blind spot was identified in the Acacia Seclusion room (not Maple ward).2. Arran Ward does not exist.	1. Work to Stewart House has been commenced for bathroom facilities. This work is being funded through Capital Bid. 2. Liaise with UHL re storage of equipment. Review PLACE inspection. 3. To seek advice if appropriate to enter on to Risk Register. 4. Team manager to look at the environmental requirements to move the existing Clinic Room to another area within Stewart House. 5. To review medication times with a possibility of having the 1 clinic room within Stewart House. 6. To discuss capital bid to relocate the male clinic room at Stewart House . 7. Escalate to Pharmacy regarding the need for capital investment for air conditioning - separated out below. 8. Nursing staff have been reminded of the need to complete an e-irf when the clinic room temperatures are recorded at over 30 degrees. 9. Capital bid has been submitted by the Team manager and Band 7 OT to develop an dedicated ADL kitchen within the unit. 10. Blind spot was identified in the Acacia Seclusion room (not Maple ward). Mirror being purchased and installed to ensure there are no blind spots on Acacia.	1. Work is being completed to address some poor environmental issues at Stewart House. 2. To spot check storage space and look at appropriate storage of equipment with UHL senior staff. 4. Stewart House: To identify another area/room within Stewart House and look at appropriate replacing and location of the clinic room and 5. reviewing medication times. 6. & 7.To look at work that would need to be carried out - works/maintenance and IT department . 8. The Willows: Continued liaison with pharmacy regarding room temperatures; staff to continue to submit e-irfs. Team Manager to follow up capital bid process and update progress on risk register. 9.Team Manager to continue to liaise with the Business Department regarding the progress of the capital bid. 10.The seclusion mirror is a standing agenda item on the weekly management meeting until the work to put in a seclusion mirror on Acacia has been completed.	1. Monitor work which has been carried out. 2. Time to review/spot check storage space and discuss with UHL management on site. 3. Time through 1-1 to discuss with service manager if appropriate to be entered on to the risk register. 4.5.6.7. Time to scope possible changes and discuss with maintaince and IT departments. 9. Requires Capital bid to be supported by LPT Finance and Performance Commitee. 10. Cost on local budget. ECF approved for purchase and works	28/04/2017 30/04/17 TBC 28/04/17	No immediate risk to staff or patients. Risk of medication degrading due to being subjected to higher temperatures either in the clinic room cupboards or in the fridges due to fridges failing as a consequence of the high ambient temperature. Medication is therefore less effective, impacting on the patient's treatment regime and recovery. OT are only able to offer limited cooking assessments and cookery skill maintenance in the unit due to having to share access to the kitchen with the housekeeping staff. Being able to cater for oneself being a basis tenet of being able to function independently. Patients have to use industrial rather than domestic equipment which does not replicate the appliances that they would use in an independent environment. Constant interruptions from housekeepers and delivery staff impact on the therapeutic environment and levels of concentration of both patient and assessing staff. Potential risk of self harming activity being undertaken in blind spot.	Team Managers and Senior Matron Team Managers and Team administrator						
		AMH/LD	9.2.7	Long stay/rehabilitation mental health wards for working age adults	see above	7. Escalate to Pharmacy regarding the need for capital investment for air conditioning	as above	as above	as above	as above	as above						
10	The trust had not ensured that people received the right care at the right time by placing them in suitable placements that met their needs.	Corporate	10	LP NHS Trust Report	The trust had not ensured that people received the right care at the right time by placing them in suitable placements that met their needs.	The Trust will undertake a detailed transformation project: Admissions, Patient Flow & DToC working in partnership with Local Authorities and Housing. The project focuses on Length of Stay, Discharge Planning and enhanced care pathways for patients with PD and complex housing needs, for example. This also includes step down. A LoS oversight group chaired by the LPT Medical Director has been established to monitor long stay patients (90days +). The Bed Management SOP has been revised and implemented.	Fortnightly meetings of the LoS Oversight Group, dashboards/metrics and CQUIN reports (May 2017), number of patients placed in OOA beds, LoS, DToC performance	Being determined on an on-going basis	Action underway		Head of Service ICL	Assurance regarding the management of risk to be provided periodically as agreed at compass - 30.05.17				AMHLD Divisional Assurance Group	2020
11	Medication Management	Corporate	11	LP NHS Trust Report	The trust did not ensure that medication was consistently at correct temperatures in all areas and did not take action if temperatures were outside of the correct range.	The remote monitoring system installed at the Bradgate unit needs to be broadened to cover all areas of the Trust that store temperature sensitive medication	The remote monitoring system can be interrogated to demonstrate it is functioning and alerting nominated individuals when required	Although the central processor will be able to function Trust wide there may be some resource implications on bringing individual new units on to the system. This will be a maximum of £4k per site	Rolling programme through 2017/8 financial year	Can't guarantee that meds have been stored at correct temperature but there has never been a Trust incident where this has led to patient harm	Anthony Oxley		W	w	w		
		AMH/LD	11.1	Acute wards for adults of working age and PICU	Staff were not always recording room and fridge temperatures in clinical rooms. The trust must consistently maintain medication at correct temperatures in all areas.	Fridge temperatures are now monitored through probes that report back to pharmacy and raise an alarm should the temperature go outside of the variable in place an alarm is raised and the pharmacy will notify the ward matron and senior nurse and unit manager to rectify temperature.	Action complete	Action complete	Action complete	Action complete	Action complete						
		AMH/LD	11.2	Long stay/rehabilitation mental health wards for working age adults	There was poor medicines management in relation to monitoring high doses of antipsychotic use, lack of storage space, checking expiry dates, waste disposal at Stewart House clinics and documenting consent for detailed patients. Staff who were unclear of the process for rapid tranquillisation did not have a reminder of the process to follow. Wards did not have a list of stock items.	1. Meet with Pharmacy to develop an improvement plan. 2.Order waste disposal bin for recycling in Stewart Houses clinic rooms. 3. Ensure all staff have completed Ulearn Rapid Tranquilisation training. 4. Disseminate Rapid Tranquillisation Policy with 'Read and Sign' sheet 5. Consultant Psychiatrist to undertake an audit re monitoring of high dose anti-psychotic medication at both units. Results and action plan to be fedback via CASE to local unit clinical governance meetings and actioned as required.	1. Confirm plan going forward after meeting with pharmacy to consider the issues raised 2.Order waste disposal bin for recycling need s to be ordered to ensure compliance 3. Team Managers and Ward Matrons to monitor training matrix monthly in relation to compliance with rapid tranquillisation training. Issues of non compliance to be addressed with individual staff 4. Re-audit of high dose anti-psychotic monitoring audit to indicate if there has been an improvement in the monitoring processes monitoring of training matrix.	1. Pharmacy time . 2. Cost of purchasing appropriate recycling bin. 3.Matrons time to review compliance of training matrix and the sharing of rapid tranquilisation policy . 4. Matrons to review MHA results and feedback 5. Consultant Psychiatrist time to undertake audit and re-audit.	28/04/2017	Risk to patient's physical health if staff do not follow the rapid tranquillisation policy and procedures	Team Managers and Senior Matron						
		AMH/LD	11.3	Acute wards for adults of working age and PICU	Staff had not ensured that out of date medication was disposed of appropriately.	Staff will be reminded of the correct procedure for returning out of date stock to pharmacy in between weekly pharmacy checks . Staff to be reminded of the process for returning out of date stock to pharmacy.	confirmation from pharmacy there has not been any incorrect disposal of out of date medication	Inpatient Lead time	June 2017	Risk of administration of out of date medication	Inpatient Lead						
		AMH/LD	11.4	Community based mental health services for adults of working age	4	1) Pharmacy audit to be undertaken to identify the areas and the problems.	Annual audit to monitor improvement.	1) Time. 2) Pharmacy input. 3) Equipment to store patients medication.	1) Audit by the end of July 2017.	interim arrangements will be put in place to ensure Gender specific bathroom facilities are available.	AMH Community Service Manager.						
			11.4.1	Community based mental health services for adults of working age		2) Protocol for the storage, administration and disposal of medication to be produced.	Protocol to be devised and implemented in all areas.		2) Protocol by end of Sept 2017.								
		AMH/LD	11.5	Community based mental health services for adults of working age	The trust had not implemented a recording system to track all medications.	See 11.4.1	See 11.4.1	See 11.4.1	See 11.4.1	See 11.4	See 11.4.1					Trust wide medicines risk reduction group	
		CHS	11.6	Community-based mental health services for older people	Medicine risk assessments were not in place for medicines kept in the patient's home. Not all medicine records included allergy information.	See 11.6.1 - 11.6.3	See 11.6.1 - 11.6.3	Lead Nurse, CSM Managers and CHS Pharmacy Jo Charles to creat space to meet to address this	Evidence contained within Quality and Governance Minutes this has been requested to be enacted, Band 7 Team meeting minutes, MCM meeting minutes and in random anonymised caselfile audits - by May 2017	Patients will be at risk of adverse reactons to precribed drugs if allergies are not identified prior ro prescribing	Dr Lyn Williams - HoS		W	w	w		
		CHS	11.6.1			Distribute LPT Pharmacy SOP (2013) and ensure discussion is held within MHWSOP through Band 7 meeting and MCM (Medics) on responsibilities of nurses and Medics within the SOP, on medicines, medication storage, administration (2016) including documenting allergy information	Evidence of discussion in Band 7 and MCM meeting through minutes on reaffirming responsibilities of nursing and medical colleagues responsibilities in relation to medicines records and the importance of documenting allergy information as set out in LPT Pharmacy SOP (2013)		May 2017								
		CHS	11.6.2			Band 8a's to hold Band 7's to account who will hold CPN/RMN's to account for ensuring that patient records within caseloads are completed by Nursing staff where required to include allergy information			May 2017								
		CHS	11.6.3			Random audits monthly through case supervision by Band 7's with qualified staff to evidence compliance and assure through Band 7 meeting.	Random case audits monthly through case supervision will evidence compliance in incldluing allergy information results discussed and minuted in Band 7 meeting.		May 2017								
		AMH/LD	11.7	Mental health crisis services and health based places of safety.	Staff in the crisis resolution and home treatment team were transporting medication to patient's homes in their handbags.	To obtain the correct medication transportation bags for the transportation of medication to patients in the care of the crisis team. This will ensure the safe transportation of medication.	The introduction of transportation bags will be communicated to all crisis team staff, and the use will be monitored through spot checks.	Information from pharmacy on the correct bags to be purchased	Bags to be ordered by March 3rd 2017, implementation once received and information on usage will be communicated to staff and this will be the evidence.	Service users currently receive medication so there will be no impact on service users prior to the new bags being put in place	Service Manager						

LEICESTERSHIRE PARTNERSHIP TRUST WIDE CQC ACTION PLAN 2017

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12	The trust did not ensure that staff adhered to the NICE guidelines (NG10) on violence and aggression: short term management in mental health, health and community settings.	Corporate	12	LP NHS Trust Report	The trust did not ensure that staff adhered to the NICE guidelines (NG10) on violence and aggression: short term management in mental health, health and community settings.	1. The rapid tranquilisation policy will be discussed in all staff meetings in AMH, LD, MHSOP and CAMH inpatient services, focusing on the roles and responsibilities of staff. 2. Ensure staff have the appropriate equipment to carryout physical health assessments during rapid tranquillisation.	Carryout an audit in June 2017 on rapid tranquilisation to show that 95% of all cases had had physical observations or attempted to take observations recorded . Monitor as part of the Trust Positive and Safe Work	Time/ Potentially new or replacement physical health observation equipment.	Jul-17	non taking of physical observation or not having the appropriate equipment could lead to the possible miss of adverse reaction to rapid tranquilisation	Michelle Churchard- Smith	AMHLD report advised delayed due to review of policy - revised deadline Nov 17. CHS reported as red at Aug compass				Clinical Effectiveness Group	Aug-17
13	The trust had not ensured that emergency resuscitation equipment was made immediately available for patients when receiving care and treatment	Corporate	13	LP NHS Trust Report	The trust had not ensured that emergency resuscitation equipment was made immediately available for patients when receiving care and treatment.	The Resuscitation Committee will undertake Resuscitation Council Quality Standards "Three minute walk" reviews in all identified sites, recommending where appropraite additional equipment and resources.	Resusciatation Committee Annual review	To be identified by the review	End April 2017	Initial review findings indicate all sites within the Quality Standard aceptable limit	Chair, Resuscitation Committee					Resuscitation Committee	
		FYPC	13.1	Specialist community mental health services for children and young people.	The blood pressure machines at all three locations were out of date for calibration. Therefore, staff could not ensure an accurate measure of blood pressure was being recorded.	To ensure all CAMHS blood pressure machines have been calibrated.	Spot checks.	TBA	1. End March 2017		Adam McKeown	~~Awaiting confirmation of new due dates from service to mark amber~~ New timescales not accepted at June compAss so Red				Medical devices group	May-17
			13.2			To implement a system of calibration of all equipment used in CAMHS teams.	Review of equipment calibration logs.	TBA	2. End April 2017			~~Awaiting confirmation of new due dates from service to mark amber~~ New timescales not accepted at June compAss so				Mecical devices group	
14	The trust had not ensured that patient areas were clean and well maintained and that there was sufficient furniture available.	Corporate	14	LP NHS Trust Report	The trust had not ensured that patient areas were clean and well maintained and that there was sufficient furniture available.	Following the upgrade of the Health based place of safety, the cleaning schedule will be maintained to ensure cleaning is to an acceptable level, the area within the crisis service will be maintained through the reviewed cleaning schedule following a site visit. TAKEN AS TRUST WIDE	Cleaning standards will be checked by cleaning supervisors at regular intervals, this will be recorded and appropriate action taken should it be required. TAKEN AS TRUST WIDE	Cleaning checks are part of the requirement of the cleaning schedules so this will not incur cost.	April 2017	Health based place of safety is currently relocated due to refurbishment, so service users are not using the inspected facility. Area within crisis has been attended to.	Victoria Peach	TAKEN AS TRUST WIDE				Infection, Prevention and Control Committee	Jul-17
		AMH/LD	14.1	Mental health crisis services and health based places of safety.	The environment in the health based place of safety and the crisis resolution and home treatment team were visibly unclean.	Following the upgrade of the Health based place of safety, the cleaning schedule will be maintained to ensure cleaning is to an acceptable level, the area within the crisis service will be maintained through the reviewed cleaning schedule following a site visit.	Cleaning standards will be checked by cleaning supervisors at regular intervals, this will be recorded and appropriate action taken should it be required.	Cleaning checks are part of the requirement of the cleaning schedules so this will not incur cost.	April 2017	Health based place of safety is currently relocated due to refurbishment, so service users are not using the inspected facility. Area within crisis has been attended to.	Team Manager (Bed Management), Service Manager (Crisis)	awaiting evidence of spot checks being approved by IPCC following aug compass					
		AMH/LD	14.2	Mental health crisis services and health based places of safety.	The trust had not ensured that patient areas were clean and well maintained and that there was sufficient furniture available.	Survey of wards to be undertaken in respect of furniture and additional furniture ordered where required.			June 2017		Helen Perfect Head of Service ICL/AMHLD					AMHLD Directorate Assurance Group	Jul-17
15	The trust did not ensure that staff recorded in patient notes the explaining of patients' rights under section 132 of the Mental Health Act.	Corporate	15	LP NHS Trust Report	The trust did not ensure that staff recorded in patient notes the explaining of patients' rights under section 132 of the Mental Health Act.	We shall continue to embed the new electronic Section 132 forms on RiO and Systm1 with clincians. Section 132 giving of information to be evidenced on admission and following significant changes or within one month.	The Trust shall monitor compliance with expected standards using the MHA Census which monitors compliance at the point of care. The MHA Census is completed monthly and includes all patients subject to the MHA.	Support from the Trusts Clinical Audit Team is required. Support for completing the MHA Censes is required by all inpatient Ward Matrons	This is an ongoing process on a monthly basis.	Non compliance with the Code of Practice requirements	Regulation and Assurance Lead/ Senior Mental Health Act Adminstrator					Mental Health Act Assurance Committee	Nov-17
		AMH/LD	15.1	Forensic inpatient/secure wards	Peoples' Section 132 rights were not being explained to them or documented	Cross reference to system identifed in Action 15. In addition, a meeting with the Ward Matron shall be arranged between the management leads and service to further understand any system issues with a view to resolving those moving forward.	The Trust shall monitor compliance with expected standards using the MHA Census which monitors compliance at the point of care. The MHA Census is completed monthly and includes all patients subject to the MHA.	Time will be required to support the visit, resolve any issues, i.e. training and time to monitor compliance on a monhtly basis.	Monthly monitoring with expected improvement 3/12 post meeting or sooner where indicated from the monthly MHA Census. AMHLD SMT agreed date of Sept 2017 for completion of action - advised in May highlight report.	Non compliance with the Code of Practice requirements	Specialist Inpatient Clinical Director/ Head of Nursing & Regulation & Assurance Lead					
16	The trust did not ensure that actions were taken to address the failure to meet the targets for delivery of services, in particular the two hour response target for unscheduled care, and referrals for continence services, musculoskeletal physiotherapy and community therapy.	Corporate	16	LP NHS Trust Report	The trust did not ensure that actions were taken to address the failure to meet the targets for delivery of services, in particular the two hour response target for unscheduled care, and referrals for continence services, musculoskeletal physiotherapy and community therapy.	See actions 16.1 - 16.8 below	See actions 16.1 - 16.8 below	3. Continence service is undergoing a review with the commissioners and a transformational service redesign which will impact on service provision	See actions 16.1 - 16.8 below	Patients may not receive appropriate care in a timely way	Head of Service CHS community		W	w	w	CHS Directorate Assurance Group	Oct-17
		CHS	16.1			Newly introduced Coordinator function to clinically triage calls for 2 hour or same day response, and to dispatch staff accordingly based on clinically assessed need. Performance reporting arrangements to be established.	Review reporting and inputting of 2 hour/same day response to ensure accurate reporting of achieved 2 hour response which is monitored within the service line. Monitoring and oversight will sit with the Community Governance Group.		~~End of April 2017~~ End of August 2017			New timeframe agreed as per Compass on 30.05.17					
		CHS	16.2			Training and supervision to be provided to all coordinators , including triage and assessment skills to ensure competencies.	Review reporting and inputting of 2 hour/same day response to ensure accurate reporting of achieved 2 hour response which is monitored within the service line. Performance reporting arrangements to be established. Monitoring and oversight will sit with the Community Governance Group.		20 March 2017								
		CHS	16.3			Review of Tissue Viability and Continence Service to standardise clinic and home based assessment and treatment and target response rate to be reviewed.	Monitoring and oversight will sit with the Community Governance Group and will be reported via the new hub reporting processes.	Continence service is undergoing a review with the commissioners and a transformational service redesign which will impact on service provision	End of April 2017								
		CHS	16.4			Tissue Viability Team and Continence Teams to support clinic review and to provide specialist staff and staff with specialised skills to staff Clinics.	Monitoring and oversight will sit with the Community Governance Group and will be reported via the new hub reporting processes.		~~End of April 2017~~ End of June 2017			New timeframe agreed as per Compass on 30.05.17					
		CHS	16.5			MSK to work with acute colleagues and commissioners to develop a new LLR model to implement self referral and telephone advice to provide a more responsive service.	Dashboard has been developed to allow timely monitoring of activity and weekly waiting time reports are issued and monitored.		September 2017								
		CHS	16.6			Community Therapy will review the triage process and use of prioritisation criteria to ensure that patients are being seen appropriately. DQIP dashboard to be developed to monitor performance.	Fortnightly meetings with operational leads to disucss performance. Indicative targets set for staff and supported through regular supervision.		September 2017								
		CHS	16.7			Process for reviewing and cleansing longest waiters on a regular basis to be documented.	DQIP dashboard to be developed to monitor performance. Fortnightly meetings with operational leads to disucss performance. Indicative targets set for staff and supported through regular supervision.		September 2017								
		CHS	16.8			All Fast Track end of Life and preferred place of death discharges from acute and community hospitals are to be assessed by Hospice at Home service.	Improvements will be overseen through the new integrated module and monitored through refer and referral.		August 2017								
17	The trust did not have system in place to provided treatment in care without significant delays in regards to assessment and treatment of patients in the community and patients on internal waiting list were not regularly reviewed.	Corporate	17	LP NHS Trust Report	The trust did not have systems in place to provided treatment in and care without significant delays in regards to assessment and treatment of patients in the community and patients on internal waiting list were not regularly reviewed.	see 17.1	see 17.1	see 17.1	see 17.1	see 17.1	see 17.1		W	w	w		
		AMH/LD	17.1	Community based mental health services for adults of working age	The trust had not ensured that waiting times between assessment and treatment were kept to a minimum	1) Patient tracking list (PTL) meeting set up in all community teams to monitor all referrals and waiting times between referral, assessment and treatment.	1) 2-4 weekly PTL meetings going forward. 2) Review of PTL process once all PTL meetings have been held for 6 months.	1) Staff time. 2) Admin Manager to collate and present all data.	1) Commencement available now. 2) Review September 2017.	Longer waiting times.	Rosie Klair, Admin Manager				w		

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		FYPC	17.2.	Specialist community mental health services for children and young people.	The trust had a large number of young people awaiting treatment and waits for certain treatements were up to 108 weeks.	See 17.2.1 - 17.2.7	See 17.2.1 - 17.2.7	See 17.2.1 - 17.2.7	See 17.2.1 - 17.2.7		Adam McKeown		W	w	w	Finance & Performance Committee	Dec-17
			17.2.1			Develop and implement a case review tool to enable identification of clinical priority cases on waiting lists of over six months.	Waiting list contains CAMHS patients waiting to be seen in order of clinical priority.	CAMHS Recovery & Improvement Team.	End April 2017.								
			17.2.2			Appointment booked for priority list.	Appointments arranged.	CAMHS Recovery & Improvement Team.	End April 2017.								
			17.2.3			To implement a system to review all patients on waiting lists every six months using the standardised caseload review tool.	Implement a post Access patient tracking list (PTL)	FYPC Business Team	End June 2017.								
			17.2.4			Redesign waiting lists so they are aligned to the treatment care pathways where clinically appropriate.	Waiting lists are clearly aligned to CAMHS treatment care pathways.	CAMHS Recovery & Improvement Team.	End August 2017								
			17.2.5			The design and implementation of time limited packages of care aligned to current evidence-based treatment care pathways.	Packages of care are clearly defined.	CAMHS Recovery & Improvement Team.	End August 2017								
			17.2.6			Review SystmOne configuration and identify changes that will support the process of waiting list and case load management.	Regular review of caseload management.	CAMHS Family Service Manager	End June 2017								
			17.2.7			Implement a standardised booking system for all CAMHS appointments to improve efficiency.	An efficient booking system in place for all CAMHS services.	FYPC Administration Manager	End November 2017								
		CHS	17.3	Community-based mental health services for older people	Assessing risks for referrals and waiting lists risks were not always managed effectively.	1. PTL Tracking Lists in place 2. Develop a SOP with clear steps through a process map 3. Risks on the risk register 4. Allocating referrals to other professionals as appropriate 5. Intensive management oversight of wait list and interventions on a monthly basis through CMHT Manager meeting 6. Closer monitoring and supervision through management supervision through referrals through, wait lists and discharges 7. Implementation of a pilot project of the Caseload Complexity Tool 8. Employing 10 Golden Rules to managing waitinglists http://www.gov.scot/Publications/2003/09/18035/25475	Evidence of monthly oversight and assuarnce of implementation of actions through meeting minutes, graphs and charts evidencing progress, breaches data and actions, by HoS Dr Lyn Williamds with Band 8a CSM's and Band 7's Team Leads. In addtion evidence of monitoring through Governance and Quality Meetings minutes, reports into G&Q in relation to waiting times and actions, weekly scrutiny of wait list and flow by 8a's with Band 7's (Evidenced by publication of the data weekly), evidence of PTL tracking meetings (Evidenced by minutes) and expected outcomes are to manage teams and work flow to meet the agreed 6 week wait target and no breaches.	Staff, Time, HoS, CMHT Managers, Patients	Immediate 02/03/17 - Evidence in CMHT Managers meeting minutes, PTL tracking lists minutes, risks on risk register and reviews, published weekly flow data to band 7's, Pilot project Minutes, impact of tool data on caseloads, evidence of 10 golden rules to managing wait lists being used to review progress at CMHT mananger and Band 7 meetings.	Patients will be at risk of harm and distress if delays are not addressed in regards to assessment and treatment of patients in the community presenting to our services	Dr Lyn Williams - HoS						
18	The trust did not ensure that staff were supervised and appraised in line with trust policy.	Corporate	18	LP NHS Trust Report	The trust did not ensure that staff were supervised and appraised in line with trust policy.	See 18.1 - 18.7	See 18.1 - 18.7	See 18.1 - 18.7	See 18.1 - 18.7	See 18.1 - 18.7	Alison O'Donnell		W	w	w	Strategic Workforce Group	Nov-17
		AMH/LD	18.1	Community based mental health services for adults of working age	The trust had not ensured that staff received annual appraisals.	1) All AMH Community staff who are at work and out of date with their appraisal (not on sick leave or maternity leave) will have an appraisal date booked with their appraiser by the end of February.	Service Manager, Team Managers, Team Leaders and Admin Managers to check the monthly training reports and discuss with staff during supervision.	1) Staff time. 2) Ulearn. 3) Computer/laptop.	March 2017	N/A	AMH Community Service Manager						
		CHS	18.2	Wards for older people with mental health problems.	Not all staff was recording when supervision had taken place.	1. Comprenhsive supervision and appraisal action plan in place within CHS 2. Heads of Service and Nursing Leads held to account for delivery 3. Trajectory being set with teams to meet minimum 85% compliance 4. Appraisal Compliance monitored through CHS Workforce Group 5. Data on compliance to inform performance through monthly Learning and Development	Assured through Governance and Quality Assurance Groups, CHS Workforce and CHS DAG	Staff, Time,Managers, Clinicians	Immediate 02/03/17	Clincians will not be supported in their continuing clincial professional development and not be clear of clincial and contractual expectations in regards to thier work with patients. Ultimately, patients will be potentialy at risk of harm and below quality standard service delivery due to the potential of unsafe practice if clincians are not engaging in professional development and reflective practice. Clinicians would also risk not being able to reregister without evidence of CPD.	Kathy Feltham Lead Nurse/Dr Lyn Williams HoS						
		CHS	18.3	Wards for older people with mental health problems.	Not all staff was receiving regular supervision.	See 18.2	See 18..2	See 18..2	See 18..2	See 18..2	Kathy Feltham Lead Nurse/Dr Lyn Williams HoS						
		AMH/LD	18.4	Mental health crisis services and health based places of safety.	Not all staff received supervision on a regular basis.	Clinical Supervision arrangements within the service will be reviewed and a system set up to ensure all staff receive clinical supervision in line with the Trust Policy	Monitoring the rates and quality (self reported by supervisee) of clinical supervision on the monthly reporting via ulearn	Agreed and planned protected time on wards/ teams and additional support to areas via Senior Matrons, Clinical Educators, AHP Leads to provide supervision sessions.	30/06/17	Usually staff would seek advice related to clinical care on an informal basis if required	Head of Nursing AMH/LD						
		AMH/LD	18.5	Acute wards for adults of working age and PICU	The trust had not ensured all staff were in receipt of regular supervision. The trust could not be sure staff were appropriately supported for their role.	Process has been developed by Clinical Trainer & Practice Development Facilitator and senior nurses to ensure all staff receive and understand the need for supervision. This is alongside a new process where managers are able to input supervision for the staff having received into ulearn.	Supervision on the training record will show above 85 %	Sufficient staff in position, clinical trainers assisting with ward matrons in enabling clinical supervision.	target of completed supervision met by September 2017	See 18.4	Senior Matrons						
		AMH/LD	18.6	Forensic inpatient/secure wards	The trust had not ensured that all staff were in receipt of supervision.	Process has been developed by Clinical Trainer & Practice Development Facilitator and senior nurses to ensure all staff receive and understand the need for supervision, this is alongside a new process where managers are able to input supervision for the staff having received into ulearn.	Supervision on the training record will show above 85 %	Sufficient staff in position, clinical trainers assisting with ward matrons in enabling clinical supervision.	target of completed supervision met by September 2017	See 18.4	Senior Matrons						
		AMH/LD	18.7	Wards for people with learning disabilities.	Staff did not receive regular supervision in line with the trust policy.	Baseline audit of supervision from staff. Supervision tree designed and implemented for all staff. Centralised booking of supervision implemented per staff member. Monthly trajectory established for improvement created. Reporting to LD business or Governance meeting each month.	Appraisal and Supervision will be recorded through the trusts Ulearn system and will be reported as part of the mandatory training report. Evidence of supervision tree and plan available.	No Additional resources required.	See 18.4	See 18.4	Team manager LD inpatient services.						
19	The trust had not ensured that staffing skill mix and that staff were adequately qualified and experienced to meets patient need.	Corporate	19	LP NHS Trust Report	The trust had not ensured that staffing skill mix and that staff were adequately qualified and experienced to meets patient need.	The staffing in all AMH/LD areas will be reviewed using the latest recommended safer staffing tools and experience of staff included. Plans will be put in place following this to look at recruitment, retention and redistribution of staff.	Continue monitoring of safer staffing on a monthly basis, review of staffing related incidents, recruitment reports		~~31/05/17~~ Safer staffing reports for all areas with mitigations detailed. August 2017	The Trust has a bank staff service with staff trained in core mandatory training to reduce impact on patient care. The Trust also has a group of agencies that can provide staff where necessary.	Bal Johal		w	w	w	Strategic Workforce Group	Oct-17
		AMH/LD	19.1	Acute wards for adults of working age and PICU	The trust had not ensured there were sufficient registered nurses for safe care and treatment.	See 19	See 19	See 19	June 2017	See 19	See 19	May CompAss - Staffing review taking place using new tools. Expect complete June 2017. June Compass - 19 and 19.1 now in Q4 17/18.					
		AMH/LD	19.2	Long stay/rehabilitation mental health wards for working age adults	Staffing levels were not consistent across the two sites. There were high vacancy rates. Staffing numbers were met but not always the right skill mix.	Stewart House and the Willows are two separate geographical sites with very different internal ward designs. The geography and ward layout determines whether certain pts. are placed at Stewart House or the Willows dependent upon their presentation and needs i.e. physical health needs v risks of violence and aggression. This in turn can impact on the staffing levels required at each unit. 1. A Staffing Review to be undertaken across the Rehab services to ensure that there is the correct skill mix and appropriate staffing numbers by AMH/LD Lead Nurse 2. Continue with overall AMHLD recruitment programme 3. SOP flow chart for use of bank and agency staff has been developed and to be disseminated to staff in both units	1. Outcome of the completed staffing review to be escalated to senior clinical and operational managers 2. Regular review of vacancies in unit management meetings and prompt recruitment to vacancies where possible. Further consideration may need to be given to TAP in the future as a/ part of the staffing review b/ in the event of difficulties recruiting to Band 5 posts in the future due to predicted national shortages. 3. Reduced staffing levels and impact on clinical care should be reported through e-irf and monitored by Team Managers 4. All staff to be aware of SOP. Final version to be distributed via email/staff meetings, newsletter, placed in the handover folder etc.	1. Capacity of Lead Nurse to undertake staffing review at both Rehab unit 2. Possible financial resource implications 3. Possible recruitment implications	~~31/05/17~~ August 2017	No immediate risk to staff or patients but potential risk of quality of care delivery if staffing skill mix is not adequate or there is heavy use of bank and agency staff to achieve required numbers of staff on shift	Team Managers and Senior Matron	May CompAss - 19.0 and 19.2 will be completed in August 2017. June CompAss - 19.2 to be completed August amd reported in Sept 2017.					
		AMH/LD	19.3	Community based mental health services for adults of working age	The trust had not ensured there was sufficient staff so that caseloads were manageable.	1) Active recruitment taking place. 2) Use of Bank and Agency staff. 3) Pilot of MH caseload complexity tool in West County CMHT commences April 2017. 4) Introductrion of nurse-led clinics.	1) Continued use of Bank and Agency staff to cover sickness and materning leave. 2) Still mix reviews -result of the pilot	1) Ongoing staff time to follow recruitment processes. 2) Senior nurse plus team staff.	1) Immediate 2) September 2017.	Lack of staff to provide basic level of care required.	AMH Community Service Manager						

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		CHS	19.4	Community health services for adults	The trust had not ensured that staffing skill mix and that staff were adequately qualified and experienced to meets patient need.	See 19.4.1 - 19.4.6	Montoring and oversight will sit with the Community Governance Group and will be reported via the new hub reporting processes	Staff capacity to deliver	See 19.4.1 - 19.4.6		See 19.4.1 - 19.4.6		W		w		
			19.4.1	Community health services for adults	The trust had not ensured that staffing skill mix and that staff were adequately qualified and experienced to meets patient need.	Develop and maintain a real time staffing spreedsheet on shared drive to enable real time monitoring of vacancy levels and early warning of leavers.			June 2017		Matrons						
			19.4.2	Community health services for adults	The trust had not ensured that staffing skill mix and that staff were adequately qualified and experienced to meets patient need.	Daily staffing sit rep to be reviewed by matrons to ensure equitable and safe staffing across each hub/locality.			June 2017		Matrons						
			19.4.3	Community health services for adults	The trust had not ensured that staffing skill mix and that staff were adequately qualified and experienced to meets patient need.	CELs to develop a programme to support training and development review.			June 2017		David Leeson						
			19.4.4	Community health services for adults	The trust had not ensured that staffing skill mix and that staff were adequately qualified and experienced to meets patient need.	None recurrent money to be used to enhance capacity of clinical trainers across each locality.			June 2017		Rachel Dewar						
			19.4.5	Community health services for adults	The trust had not ensured that staffing skill mix and that staff were adequately qualified and experienced to meets patient need.	DN's to be supported by CeIs to increase clinical competency			June 2017		David Leeson						
			19.4.6	Community health services for adults	The trust had not ensured that staffing skill mix and that staff were adequately qualified and experienced to meets patient need.	Lead Nurse to work with DN's to increase complex patient facing time to meet fair days work levels			June 2017		Tracy Yole						
20	The trust did not ensure staff within community health services received appropriate support, training, professional development, supervision and appraisal as necessary to enable them to carry out the duties they are employed to perform.	Corporate	20	LP NHS Trust Report	The trust did not ensure staff within community health services received appropriate support, training, professional development, supervision and appraisal as necessary to enable them to carry out the duties they are employed to perform.	1 - Understand the reasons/gap that has led to this. 2 - On the back of (1) revise/amend & possibly add to existing support/training packages, 3 - increased scrutiny/reporting at divisional and corporate level.	Monitored through SWG and divisional workforce groups	To be done within existing training recourses and will need divisional and Training manager input	Initial gap analysis with outline action plan by the end April/start May	Staff may not have the necessary skills and/or support to enable them to provide appropriate patient care	Michelle Brookhouse	Agreed at Sept meeting (04.10) that this is covered by actions detailed below and should not be rag rated separately	W		w	Strategic Workforce Group	Oct-17
		AMH/LD	20.1	Acute wards for adults of working age and PICU	The trust had not ensured all staff were up to date with mandatory training requirements. The trust reported low levels of compliance with immediate life support training. The trust was required to address this following the CQC inspection in 2015.	All ward matrons and the training department have been made aware of the need to have all staff up to date with ILS and will book staff onto this training, training department are aware of the high demand and are in the process of informing wards if spaces become available at the last moment to attempt to ensure course are ran at full capacity. Training reports will be looked at with matrons during their supervision sessions to address any needs that may arise.	all staff are trained with mandatory training and ILS	sufficient trainers available for the number of courses needed to train all staff All staff are booked on in a timely manner for courses	September 2017 training report to show greater than 85% completion	Patient care may be adversely affected by staff not being up to date with their mandatory training and staff are at risk of delivering care that is not compliant with latest practice	Inpatient Lead						
		CHS	20.2	Community health services for adults	The Trust must make sure staff receive appropriate support, training, professonal development, supervision and appraisal as necessary to enable them to carry out the duties they are employed to perform	Supervision and appraisal recording in each hub to achieve achieve 80% by 30 June and 85% by 30 Sept. Delivery is to be incorprated into daily care planning arrangements for teams to build capacity to complete. Also see 5.5 & 19 for supporting actions.	Monitoring and oversight will sit with the Community Governance Group and will be reported via the new hub reporting processes. Reporting will be via the workforce sitreps.	Staffing capacity to ensure that supervision and appraisal is undertaken	30th Sept 2017	Patients may receive care and treatment from a workforce without the appropriate skills to deliver effective care	Matrons, Clinical Leads and DN's						
21		AMH/LD	21	Community based mental health services for adults of working age	The trust had not ensured that the patients had their allergy status recorded to prevent allergic reactions.	1) Memo to all staff to remind them to record the allergy status of patients bi-annually. 2) Staff to be reminded during clinical supervision to record allergy status. 3) CEG to review again the decision for adding allergy status as a mandatory field on RiO (Corporate action)	2) Bi-annual record keeping audit to check improvement in recording allergy status.	1) Time. 2) Memo. 3) Clinical Audit department.	1) Memo to be circulated by the end of March 2017. 2) Bi-annual audit May 2018. 3) TBC by CEG	Patients may be prescribed medication they are allergic to.	Head of Service CPH	Query whether AMHLD DAG should be responsible or CEG in light of 21.3?	W		w	AMHLD Divisional Assurance Group	Jun-18
			21.1			Memo to all staff to remind them to record the allergy status of patients bi-annually.			Memo to be circulated by the end of March 2017.							AMHLD Divisional Assurance Group	
			21.2			Staff to be reminded during clinical supervision to record allergy status.			Bi-annual audit May 2018.							AMHLD Divisional Assurance Group	
			21.3			CEG to review again the decision for adding allergy status as a mandatory field on RiO (Corporate action)			TBC by CEG							Clinical Effectiveness Group	Jun-18
22		AMH/LD	22	Community based mental health services for adults of working age	The trust had not ensured that the healthcare records of the patients were available to all relevant staff	1. This action can be linked to the Trust wide scanning project where all current patient related documentation will be scanned into RiO and removal of secondary (pink files). This should be a corporate action. 2. ~~All CMHT Staff should ensure that any reference to historic records is included in the alert notification on RiO e.g. records prior to xxx are in archive storage at C&V.~~ Action 2 revised to:- a reminder is sent to all relevant staff re historic records being located off site and how to access them.	1. This will be included as part of the Benefits Realisation Strategy associated with the Trust-wide document scanning project. This should be a corporate action. ~~2. Spot check audits of records as part of a peer review.~~ 2. Copy of memo	1. Resources will fall in line with the Trust-wide Document Scanning Project. This should be a corporate action. 2. No additional resources required	1. The Trust wide Document Scanning Project is expected to run for 2-years (April 2019) 2. ~~For AMH/LD to provide~~ 2. June 2017	1. Mental Health Serivce users in Adult Services 2. For AMH/LD to provide	1. Sam Kirkland - Service Lead for the Document Scanning Project ~~2. For AMH/LD to provide~~ 2. Community Service Manager	Action redrafted as agreed at CompAss - 30.05.17.				AMHLD Divisional Assurance Group	May-19
23		CHS	23	Community-based mental health services for older people	Consent to treatment was not properly sought and recorded.	Trust wide MCA and DoLS action plan	Trust wide MCA and DoLS action plan	Lead Nurse, managers, Clinicans	immediate 02/03/17	Patients will be put at risk of not consenting to treatment and as such this would be potentially unlawful and unethical act	Head of Service CHS community	as per 5.0 - Agreed complete with HD as per 5.0 which would be blue if actions below it were completed - 09.10.17 CDH				CHS Divisional Assurance Group	May-18
24		AMH/LD	24	Mental health crisis services and health based places of safety.	Staff in the crisis resolution and home treatment team were not reviewing and updated risk assessments regularly or following an incident.	Staff working within the crisis team will ensure that they complete a review of the risk assessment following a clinical incident. This will be raised in both the operational team meeting and with individual team members.	Regular care plan audits will be used to measure success	No further resource required as this forms part of the current audit process within the crisis team	Issue highlighted to staff and supervisors will continue to review	Risk of out of date information in risk assessments in care records	Head of Service ICL	Apparently date had not been agreed and now agreed at SMT in May as Sept 2017				AMHLD Divisional Assurance Group	~~01/04/2017~~ Sept 2017
25		FYPC	25	Specialist community mental health services for children and young people.	At the Valentine Centre, in the waiting area, a cupboard containing cleaning products was unlocked, which posed a risk to the young people.	1. To ensure all cupboards containing cleaning products at the Valentine Centre and all CAMHS bases are kept locked. 2. All staff to be made aware of the risk to patient safety if a cupboard containing cleaning products is left unlocked.	1. Spot checks of cleaning cupboards. 2. communication to staff.	CAMHS Recovery & Improvement Team.	1. End March 2017 2. End March 2017		Head of Service FYPC Group 1 & LD					FYPC Divisional Assurance Group	Apr-17
26		AMH/LD	(Previously 14.1)	Acute wards for adults of working age and PICU	One ward had nurse call alarms that were not in working order.	Nurse call system has been costed and is going through a capital bid process. Review outcome of capital bid and plan for call bell installation including risk management and alternatives.	Clear plan for works and timescales if appropriate or management of risk (dependent on the decision made re call bell provision)	TBC	TBC	Risk of patient being unable to raise the alarm managed via observations as appropriate	Inpatient Lead	reported to july compass that work is expected to conclude in Oct 2017 one month later than original target - however original target is July!				AMHLD Divisional Assurance Group	Jul-17
27		AMH/LD	(Prevously 14.2)	Acute wards for adults of working age and PICU	One ward had a damaged shower fitting and toilet roll holder that posed a risk to patient safety	The repairs are complete	N/A	N/A	N/A	N/A	N/A					AMHLD Divisional Assurance Group	May-17
2015/23	The Trust must review its procedures for maintaining records, storage and accessibility		23.1	Provider Level Report	OVERARCHING TRUSTWIDE ACTION	c.) We will develop an EPR Policy for the Trust	CEG to review, progress and provide direct assurance to QAC		~~anticipate adoption by QAC in June 2017~~ see column N		Head of Information Governance	policy on electronic record keeping no longer considered best way forward. To be incorporated into Record Keeping and Care Planning Policy currently in draft - July 2017				Clinical Effectiveness Group	????