CQC Quality Report Action Plan

RXE SPL1-2030482351 **Version 8** **Date: 03/10/2016**	**Governance Process:** Board of Directors Executive Management Team Quality Committee Quality and Safety Sub-Committee Accountable Directors Accountable Assistant Directors / Care Group Directors	**Themes:** - Record keeping - Duty of candour - Information technology systems - Care planning - Risk assessment - Medicines management - Mandatory and statutory training - Culture and attitude - Consent and Mental Capacity	**Trust Work Programmes:** - Listening into Action - Unity - CQUIN - Transformation - Revalidation - E-rostering - Smoke-Free - Care Records Audit - Patient and Public Engagement and Experience Strategy - Physical Health and Wellbeing Programme

Introduction

In September 2015 the Care Quality Commission (CQC) undertook a planned inspection of Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH). Following this inspection received an overall rating of 'Requires Improvement', with ratings of 'Good' the three Domains of Caring, Responsive and Well-Led and ratings of 'Requires Improvement' in the Safe and Effective Domains. In addition, the Trust received a total of 14 service level reports, the ratings from which were:

- 2 x Outstanding
- 8 x Good
- 4 x Requires Improvement

Contained within these reports and the Trust's overall Quality Report were a numbers of actions for the Trust to take forward. This action plan has therefore been developed to present the Trust's progress with these actions and provide assurance to the Trust's patients, carers and communities that these actions have been taken forward. The most recent version of the Action Plan also contains the following additional columns to demonstrate the sharing of learning from across the organisation and the oversight of these improvements at all levels of the organisation:

- *'Leading the Way with Care'* - provides detail when the requirements of an action from the CQC have been exceeded or when the Trust has 'gone the extra mile' to achieve the actions.
- *'Golden Thread'* - triangulates actions with those taken in other services, themes from across the action plan or programmes of work underway across the organisation. The improvement themes that arose during the inspection were as follows: record keeping, duty of candour, information technology systems, care planning, risk assessment, medicines management, mandatory and statutory training and culture and attitude.
- *'Governance'* - provides detail on where the action has been overseen in the organisation to ensure appropriate consultation with stakeholders.

The progress of this action plan has been overseen both internally and externally through the following groups:

- Board of Directors
- Quality Committee
- Executive Management Team
- Local Safeguarding Boards
- Commissioner Quality Meetings

It is intended that completion of these actions will form Phase 1 of the Trust's current Quality Improvement Strategy and following completion of these there will be a Phase 2 Sustainable Improvement Plan developed that will focus on ensuring that the achievements across services are embedded into practice and continue to improve the service that we deliver to our communities.

Action Status Code: Action Achieved | Action on Target for Completion | Action Not on Target

Ref	CQC Requirements	Action Agreed	Accountable Director	Accountable Assistant Director / Care Group Director	Timescale	Progress Comments	Leading the Way with Care	Golden Thread	Governance	Status
	Actions that Trust MUST take to Improve:									
	Community mental health services for people with learning disabilities and autism									
1	The Trust must ensure that the Ironstone Centre has enough staff to keep people receiving services safe.	Immediate action taken to ensure that the Ironstone Centre has sufficient staff to keep people receiving services safe.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for LD and Forensic / NL Care Group Director	04/01/2016	Non recurrent funding was agreed by North Lincolnshire Clinical Commissioning Group (NLCCG) in May 2016. RDaSH continues to provide an additional Band 3 Senior Support Worker to provide additional capacity while nurse recruitment is underway.	Business division continues to provide additional staff over current budget to service while training of newly recruited staff is underway.	Business Division Quality Improvement Plan Links to Actions 22, 50, 59 and 70.	Board of Directors Quality Committee Quality and Safety Sub Committee Executive Management Team Business Division Meetings Risk Register	
		The Learning Disability Services Business Division to develop a business case to submit to the North Lincolnshire Clinical Commissioning Group for additional funding from April 2016 to provide increased staffing levels.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for LD and Forensic / NL Care Group Director	31/03/2016	The Trust business case to request additional resource for the Ironstone Centre was completed and submitted to North Lincolnshire Clinical Commissioning Group (NLCCG) in January 2016. The business case was presented at the NLCCG Contract Management Board on 23/02/2016. A NLCCG Engine Room Meeting took place on 07/04/2016 and non-recurrent funding was agreed by NLCCG. Contract variation now signed and in place for 2016/17. All additional posts are now recruited to, with the exception of the Primary/Acute Liaison Nurse. Start dates for each post as follows: - Band 6 Community Team - commenced 1st July 2016 (promotion from within Team, formerly Band 5) - Band 6 Intensive Team - commenced 1st August 2016 (promotion from within Team, formerly Band 5) - Band 5 Community Team - commenced 1st August 2016 - The two above promotions have resulted in two Band 5 vacancies, with the position as follows: - 1 x Redeployed nurse successfully completed 4 week trial and is now working substantively within the Team. - 1 x currently out to advert (candidate was appointed as per update provided in Version 6, however, backword was given)	Quality Review undertaken on 25 May 2016 with positive feedback received. Senior Managers Visibility plan developed to ensure continuous engagement with and feedback from staff. Director of Nursing and Quality undertook visit to Team on 21 July 2016 where the feedback provided by staff was very positive and the improvements and changes made since the business case was submitted were noted. Chief Executive and Chief Operating Officer undertook visit to Team on 31 August 2016 where positive feedback was reiterated.	Business Division Quality Improvement Plan Quality Review Report Listening into Action	Board of Directors Quality Committee Quality and Safety Sub Committee Executive Management Team Business Division Meetings	

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5	Ref	CQC Requirements	Action Agreed	Accountable Director	Accountable Assistant Director / Care Group Director	Timescale	Progress Comments	Leading the Way with Care	Golden Thread	Governance	Status
10	2	The Trust must ensure that staff complete risk assessments and update them within given timescales or where a change in risk is identified.	Undertake a comprehensive review of completion of the FACE Risk Assessments in all localities.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for LD and Forensic / Care Group Directors for Rotherham / Doncaster / NL	18/01/2016	The process and standards for the undertaking of FACE Risk Assessments has been reviewed, updated and circulated to staff.		Theme: Record Keeping and Risk Assessment Links to Actions 7, 12, 19 60 and 65. Care Records Audit	Business Division Performance and CQUIN Group Business Division Records Sub Group	
11			Implement monitoring system into business division governance arrangements to ensure that improvements are sustained.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for LD and Forensic / Care Group Directors for Rotherham / Doncaster / NL	18/01/2016	Monitoring of uptake of Risk Assessments has been incorporated into terms of reference for the Learning Disability Business Division Performance Group and is a standing agenda item. Papers are received detailing current levels of risk assessments undertaken on a monthly basis. Any reductions in the numbers of risk assessments undertaken are escalated via the Business Division and Trust Quality and Safety Sub-Committee. Compliance reports run on 10/08/2016 show that all localities remain over 90% compliant with uptake of FACE risk assessment and monthly monitoring continues.	SystmOne template redesign to make FACE Risk Assessment into Questionnaire, making this easier for clinicians to complete and also facilitates reporting on compliance	Theme: Record Keeping and Risk Assessment unity	Business Division Performance and CQUIN Group Business Division Records Sub Group	
12			Clinical Audit to be completed on implementation of FACE Risk Assessment, the nationally accredited risk assessment tool used within the Trust.	Executive Director of Nursing and Quality	Assistant Director for LD and Forensic / Care Group Directors for Rotherham / Doncaster / NL	30/09/2016	Trust Clinical Records Audit has now commenced with data collection completed by 14 July 2016. Results are current being collated, analysed and populated into reports. The initial results for the Learning Disabilities Business Division are that in 88% of records 'management of patient risks was included in the care plan / risk management plan' and an action plan has been developed to strive for continuous improvement.	Criteria for Trust Clinical Records Audit updated in 2016/17 to capture review of records and risk assessments and also the robustness of risk assessments.	Clinical Records Audit	Quality and Safety Sub-Committee Clinical Quality and Standards Group	
13	3	The Trust must ensure that staff complete environmental risk assessments for all locations to ensure the safety of people who use services and staff.	Environmental Risk Assessment to be completed for Badsley Moor Lane, Rotherham Community Learning Disability Team.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for LD and Forensic / Care Group Directors for Rotherham / Doncaster / NL	31/01/2016	Health, Safety and Security Team visited Badsley Moor Lane on 06/01/2016 to undertake comprehensive, independent Environmental Risk Assessment. Report completed, action plan devised and completion to be monitored by the Health and Safety Team and any issues escalated to the Trust Risk Management Sub Group. A further Environmental Risk assessment was completed by the service in February 2016 to compliment review already undertaken by Health, Safety and Security Team. Trust Security Officer undertook a follow up visit to 220 Badsley Moor Lane on 29/05/2016 and identified that no further work is to be undertaken to enhance safety of clinic rooms. Agreed that Environmental Risk Assessment should be updated, which has been completed. Environmental Risk Assessments remain in place across all Community Teams. Doncaster Community Team has recently changed bases and therefore this has been updated jointly with the Trust Health and Safety Team. Business Division Quality Governance Lead undertook visit to Badsley Moor Lane in July 2016 and incorporated into this a review of the environment. Some additional developmental changes were suggested during this visit, which have been completed but all were in support of continuous improvement and not safety issues.		Links to Actions 4 and 46.	Board of Directors Quality Committee Quality and Safety Sub Committee Executive Management Team Business Division Meetings	
14			The terms of reference of the Trust Environment Risk Group to be reviewed to encompass all aspects of risk related to the clinical environment area, including building structure, function, materials, furniture, occupancy and use.	Executive Director of Nursing and Quality	Assistant Director for LD and Forensic / Care Group Directors for Rotherham / Doncaster / NL	29/02/2016	The function of the Trust Environmental Risk in Clinical Areas Group has been reviewed. On 15/02/2016 the Clinical Governance Group approved the absorption of the Group into the Reducing Restrictive Interventions Group. The Clinical Governance Group also approved the remit of the Reducing Restrictive Interventions Group be widened to include risks from the physical environment. The Reducing Restrictive Interventions Group continues to meet regularly and receive updates and ratify decisions in relation to clinical environments, for example the Amber Lodge Seclusion Review at Action 72.		Links to Action 3 and 46.	Clinical Governance Group/Quality and Safety Sub Committee Reducing Restrictive Interventions Group	

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5	Ref	CQC Requirements	Action Agreed	Accountable Director	Accountable Assistant Director / Care Group Director	Timescale	Progress Comments	Leading the Way with Care	Golden Thread	Governance	Status
15			The Trust will provide clear guidance on which assessments are to be completed by the area/building managers in line with relevant Trust policies, with the support of the Corporate Safety Teams i.e. Fire Safety; Moving to Alternative Premises.	Executive Director of Nursing and Quality	Assistant Director for LD and Forensic / Care Group Directors for Rotherham / Doncaster / NL	29/02/2016	The annual Health and Safety and Security Assessments have been reviewed to include: - building structure - function - materials - furniture - occupancy and use In addition specific questions have been added regarding: - Security Risks - Health and Safety Risks - Manual Handling Risks - Lone Working Risks - Fire Risks - COSHH Risks - specific risks related to the work undertaken in that area. The expiry dates of all additional environmental risk assessments has been added to the action plan from the Health and Safety and Security assessment. The Trust Health and Safety intranet page has been reviewed and updated.			Clinical Governance Group/Quality and Safety Sub Committee Reducing Restrictive Interventions Group Environmental Risk in Clinical Areas Group	
16			Business Division Governance Groups to include Environment Risks as a standard agenda item. Areas of concern to be escalated to appropriate governance meeting.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities) / Service Director (Mental Health)	Assistant Director for LD and Forensic / Care Group Directors for Rotherham / Doncaster / NL	29/02/2016	All business division governance group terms of reference have been amended to include reporting of environmental risks i.e. changes in staffing, environment or patient groups, as a standing agenda item from February 2016.			Quality and Safety Sub-Committee/Clinical Governance Group	
17			The Business Divisions with support from the Corporate Safety Teams will review all community environments where clinical engagement takes place, prioritise levels of risk as identified within the Trust Environment Group.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities) / Service Director (Mental Health)	Assistant Director for LD and Forensic / Care Group Directors	31/05/2016	The Health and Safety Team complete and hold copies of all Health and Safety / Fire / Security assessments, as well as the Performance Management Report which highlights significant findings and actions. Areas of identified concern are escalated to the relevant Assistant Director/Care Group Director via the Health and Safety Team Performance Management Report. Outstanding actions (indicated as RED) have been presented at the Risk Management Sub Group, and are now presented to the Health and Safety Forum in the future. The Environmental Assessments Quick Guide has been developed to assist with assessments / who is responsible for the assessment etc. This has been posted on the Intranet home page under Support Services Health& Safety, Security and Fire. Copies of all the assessments where it is the responsibility of the department / building manager etc. are held on the premises that they relate to. Part of the Safety Team inspection is to check (evidence) the various assessments have been completed and recorded on the Workplace Environment Health Safety and Welfare Inspection. The programme of visits by the Health and Safety Team to all premises for which the Trust is responsible for continues.			Risk Management Sub Group Health and Safety Forum	
18	4	The Trust must ensure that psychiatry rooms used by Rotherham Community Learning Disability Team are made safe for staff and people who use services.	Psychiatry Rooms to be reviewed and furnished to ensure that these are laid out in a way that makes the environment safe for staff and visitors.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for LD and Forensic / Rotherham Care Group Director	31/01/2016	All non-essential equipment has been removed from psychiatry consulting rooms used by the Rotherham Community Learning Disability Team. Full refurbishment to both psychiatry clinic rooms has been completed. All actions following the Health, Safety and Security visit are now completed, with the exception of maintenance of security cameras. This is due to an external contractor but mitigating monitoring processes are in place. Business Division Quality Governance Lead undertook visit to Badsley Moor Lane in July 2016 and incorporated into this a review of the environment. Some additional developmental changes were suggested during this visit, which have been completed but all were in support of continuous improvement and not safety issues.	Full refurbishment undertaken to both Clinic Rooms at Badsley Moor Lane.		Quality and Safety Sub-Committee/Clinical Governance Group	

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5	Ref	CQC Requirements	Action Agreed	Accountable Director	Accountable Assistant Director / Care Group Director	Timescale	Progress Comments	Leading the Way with Care	Golden Thread	Governance	Status
19	5	The Trust must ensure that staff are protected from potential harm by providing access to audible alarms.	Personal Audible Alarms to be provided to all staff working in Consultation Rooms in Community Services, in line with Trust Lone Working Policy.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for LD and Forensic / Care Group Directors for Rotherham / Doncaster / NL	21/01/2016	Personal alarms have been provided to all learning disability staff working in consulting rooms in the: - North Lincolnshire Community Team - Rotherham Community Team - Doncaster Community Team Personal Attack Alarms remain in situ. Due to the configuration of buildings, an enhanced 'built in' system has been installed for Doncaster and installation is planned for North Lincolnshire (with Security Guard in place while installation is completed). Personal Attack Alarm system deemed sufficient for Rotherham due to observation from reception area and rest of building only being accessed by staff. There are therefore localised SOPs in place across all localities.		Links to Actions 46 and 47.	Quality and Safety Sub-Committee/Clinical Governance Group Business Division Clinical Governance Group	

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5	Ref	CQC Requirements	Action Agreed	Accountable Director	Accountable Assistant Director / Care Group Director	Timescale	Progress Comments	Leading the Way with Care	Golden Thread	Governance	Status
20	**Substance Misuse Services**										
21	6	The Trust must ensure that staff responsible for administering medication in the social detoxification service are suitably trained and competent.	Staff to be trained in administering medication in line with Trust medicines management policies and procedures prior to New Beginnings becoming an inpatient detoxification service on 05/10/2015.	Executive Medical Director	Assistant Director for Drugs and Alcohol / Doncaster Care Group Director	05/10/2015	Training completed for all relevant staff prior to New Beginnings becoming an inpatient detoxification unit on 05/10/2015. All medicines are administered by qualified nursing staff who received training on 30/09/2015 related to the Trust Safe & Secure Handling of Medicines Policy and administering medicine for minor ailments against a Patient Group Direction. To ensure training compliance is sustained, part of the nurses initial Personal Development Plans for those new to post is to access the following courses: Controlled drugs Medicine competencies - competent administration; oral and IM. Safe and secure handling of medicines Medicines at admission - reconciliation. Weekly clinical pharmacist audits are undertaken by the business division pharmacist and non medical prescriber (NMP) which look at drug interactions, clinical appropriateness and highlighting monitoring needs. This is in addition to the weekly visits by the Trust pharmacy technicians for stock purposes.	The ward routine has been changed to ensure that there is quiet time for the member of staff administering medication. Leadership structure has been revised to introduce a Band 6 Non-Medical Prescriber who manages and clinical leads the administration of medication on the unit. There is a Doctor on site between Monday and Friday who is able to provide clinical leadership, support and advice to staff administering medication. Deputy Director of Nursing and Quality visited the service on 12 January 2016.	Theme: Medicines Management Links with actions 13, 16, 17 and 45. Trust Pharmacy Strategy	Medicines Management Committee Business Division Medicines Management Group Business Division Clinical Governance Group	
22	7	The Trust must ensure that staff complete comprehensive risk assessments for each service user and review them regularly.	New Beginnings staff to be trained in the use of FACE risk assessment tool to increase standardisation with other parts of the Trust.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for Drugs and Alcohol / Doncaster Care Group Director	18/01/2016	The service implemented us of the FACE risk assessment tool. FACE risk assessment training completed on 18/01/2016 and to ensure sustainability, completion of assessment has now been incorporated into the local induction programme, with trainers employed within the team.			Business Division Clinical Governance Group	
23			Compliance to be monitored through supervision and audit.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for Drugs and Alcohol / Doncaster Care Group Director	31/03/2016	A programme of work has been undertaken with all members of staff in Rotherham, Doncaster and North East Lincolnshire to improve compliance with FACE Risk Assessment across services. Reports have been designed on SystmOne which show all records that do not have a FACE Risk Assessment and these are discussed with the relevant case worker. Compliance also continues to be monitored through clinical supervision.	Service is piloting use of a complexity tool that has been designed as part of Listening into Action aiming to ensure targeted assessment and management of risk. Service has implemented internal system to ensure that if a referral is received and documentation is not complete, this is passed back to the original referrer for urgent completion while also ensure that the patient journey is not impacted.	Theme: Record Keeping and Risk Assessment Links to Actions 2, 12, 19, 60 and 65. Clinical Records Audit Listening into Action	Business Division Clinical Governance Group	
24			Divisional audit of risk assessments (and care plans) to be completed during Quarter 1 2016/17.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for Drugs and Alcohol / Doncaster Care Group Director	30/06/2016	Case note audits have been undertaken in Rotherham and Doncaster and the outcomes shared within the Business Division. The results showed a positive improvement in compliance and actions have been developed and are continually implemented and monitored through the Business Division Clinical Governance Group. Work is on-going in North East Lincolnshire, as the Trust is not the lead for the service.				
25			Trust wide Care Records Audit to be completed during 2016/17.	Executive Director of Nursing and Quality	Assistant Director for Drugs and Alcohol / Doncaster Care Group Director	30/09/2016	Trust Clinical Records Audit has now been completed. Results have been collated, analysed and populated into reports. The results for the Drug and Alcohol Business Division are an overall rating of 'good' and that in 89.6% of records 'management of patient risks was included in the care plan / risk management plan' and an action plan has been developed to strive for continuous improvement.	Criteria for Trust Clinical Records Audit updated in 2016/17 to capture review of records and risk assessments and also the robustness of risk assessments.	Clinical Records Audit	Quality and Safety Sub-Committee Clinical Quality and Standards Group	
26	8	The Trust must ensure that staff prepare care plans that are comprehensive, recovery-focused and take into account each service user's physical, mental, and social conditions in the treatment of their illness, and review them regularly.	There is currently a standard care plan template in use across the Drug & Alcohol Business Division - an electronic version is in use on SystmOne. Further update training will be provided to all staff across the service in effective care planning and compliance monitored through supervision and audit.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children and Communities)	Assistant Director for Drugs and Alcohol / Care Group Directors for Rotherham / Doncaster	18/01/2016	New Beginnings staff have developed revised, holistic and recovery focussed care plan template. This has been uploaded onto SystmOne and is much more user friendly and easier for staff to complete. Simultaneously to the development of the care plan template and audit tool was also devised to ensure that comprehensive completion of the care plans can be audited appropriately and these audits are underway in the business division.	Care Planning Masterclasses have been delivered across the service.	Theme: Record Keeping Links to Actions 3, 12, 21 and 33. Care Records Audit	Business Division Clinical Governance Group	
27				Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for Drugs and Alcohol / Care Group Directors for Rotherham / Doncaster	31/03/2016	Care plans have been reviewed within the teams to support improvement and understanding through supervision. This business division has also designed a new report on SystmOne which shows all Care Plans that have not been updated within the last three months. This report is produced regularly and sent to team managers for review/action.				

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5	Ref	CQC Requirements	Action Agreed	Accountable Director	Accountable Assistant Director / Care Group Director	Timescale	Progress Comments	Leading the Way with Care	Golden Thread	Governance	Status
28			Divisional audit of care plans (and risk assessments) to be completed during Quarter 1 2016/17.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for Drugs and Alcohol / Care Group Directors for Rotherham / Doncaster	30/06/2016	Case note audits have been undertaken in Rotherham and Doncaster and the outcomes shared within the Business Division. Actions have been developed and will be implemented and monitored through the Business Division Clinical Governance Group. Work is on-going in North East Lincolnshire, as the Trust is not the lead for the service.				
29			Trust wide Care Records Audit to be completed during 2016/17.	Executive Director of Nursing and Quality	Assistant Director for Drugs and Alcohol / Care Group Directors for Rotherham / Doncaster	30/09/2016	Trust Clinical Records Audit has now been completed. Results have been collated, analysed and populated into reports. The results for the Drug and Alcohol Business Division are that in 84% of records 'a patient's care plan(s) [was] reviewed for effectiveness within specified timescales' and an action plan has been developed to strive for continuous improvement.	Criteria for Trust Clinical Records Audit updated in 2016/17 to capture review of records and risk assessments and also the robustness of risk assessments.	Clinical Records Audit	Quality and Safety Sub-Committee Clinical Quality and Standards Group	
30	**Acute wards for adults of working age and psychiatric intensive care unit**										
31	9	The Trust must review its seclusion policy to ensure that the use of a seclusion garment is detailed in the procedures.	Review Trust Seclusion Policy to incorporate information relating to the removal of clothing due to ligature risk across all seclusion suites (Rotherham, Doncaster and North Lincolnshire)	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Mental Health)	Assistant Director for Adult Mental Health / Care Group Directors for Rotherham / Doncaster / NL	31/12/2015	The Trust Seclusion policy was reviewed during December 2015 and it was agreed that anti ligature clothing would not be used. Trust policy now states explicitly that anti ligature clothing must not be used. Anti-ligature clothing is therefore no longer in use in any Trust services.	The Trust has launched a full review of seclusions facilities and practices across the Trust to ensure consistency and adherence to best practice guidance. As part of this review staff within the Trust have visited seclusion facilities in colleague organisations to benchmark practice.	Links to Actions 34, 42, 43 and 44.	Quality Committee Quality and Safety Sub-Committee Clinical Quality Review Group Reducing Restrictive Interventions Group Business Division Clinical Governance Group.	
32				Chief Operating Officer (w/e/f 01/07/2016) Service Director (Mental Health)	Assistant Director for Adult Mental Health / Care Group Directors for Rotherham / Doncaster / NL	29/02/2016	The reviewed Trust Seclusion Policy was ratified by the Clinical Quality Group on 01/03/2016. Modern Matrons undertake regular audits of compliance with the Seclusion Policy. Any exceptions are reported through the Business Division Clinical Governance Group.				

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5	Ref	CQC Requirements	Action Agreed	Accountable Director	Accountable Assistant Director / Care Group Director	Timescale	Progress Comments	Leading the Way with Care	Golden Thread	Governance	Status
33	**Community based mental health services for working age adults**										
34	10	The Trust must ensure that systems are in place to collate mandatory training figures accurately.	The division to closely monitor mandatory/statutory compliance by team and report any gaps to the Assistant Director.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Mental Health)	Assistant Director for Adult Mental Health / Care Group Directors for Rotherham / Doncaster / NL	31/03/2016	The Learning and Development Team have been visiting each of the Business Divisions to support/check that the trained administrators have any further training needs met and they will also be tasked with checking that information is being input in to the system in a timely and consistent manner. The Learning and Development Team continue to inform Assistant Directors of those staff who are not compliant in each MAST requirement so their attendance can be prioritised. Administrators in each of the Business Divisions have been identified and trained to input mandatory training information/data on to the OLM system. Compliance with mandatory/statutory training has been sustained at 89-90% since February 2016. As at 31/08/2016 compliance in the Adult Mental Health Services Business Division was 83.86%. Monthly team figures produced for Assistant Director who identifies areas of concerns and highlights to relevant team managers.	Research, Education and Development (RED) Centre have worked additional hours, including evenings and weekends to ensure that sufficient training places are available across the organisation. RED Centre have piloted and implemented the option of a 'patient ready' induction across the Trust for services where it is most beneficial for staff to have completed all requisite training before patient contact. Trust has recently undertaken a Governance Review and has subsequently formed the People's Sub-Committee which is responsible for oversight of training compliance.	Theme: Mandatory and Statutory Training Links with Actions 18, 24, 28, 36, 52, 63, 66, 68 and 75.	People's Sub-Committee/Human Resources and Organisational Development Group Education and Training Forum Business Division Clinical Governance Group	
35	11	The Trust must ensure that staff can access information relating to people who use services when required.	The division is undertaking a training needs analysis and gap analysis to ensure training is focused on individual staff competencies with the Silverlink and SystmOne patient information systems.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Mental Health) / Executive Director of Health Informatics	Assistant Director for Adult Mental Health / Care Group Directors for Rotherham / Doncaster / NL	31/01/2016	Staff were given immediate advice on how to access IT systems support mechanisms to ensure all staff are able to access information via the Trust electronic patient record system. Team Managers had immediate discussions within their team in order to identify specific access issues and plans were developed with IT on how to address these. Each team subsequently identified training needs in relation to system usage and this informed the training session that were delivered.	RED Centre have piloted and implemented the option of a 'patient ready' induction across the Trust for services where it is most beneficial for staff to have completed all requisite training before patient contact.	Theme: Information Technology Systems unity	Board of Directors Finance, Information and Performance Committee Unity Programme Board Health Informatics Sub-Committee	
36			Training sessions for adult community mental health staff to delivered.	Executive Director of Health Informatics	Assistant Director for Adult Mental Health / Care Group Directors for Rotherham / Doncaster / NL	31/07/2016	Training to be provided in response to training plan and delivered to staff. The response from clinical services has been very positive and therefore the planned time for providing appropriate training was extended until 31/07/2016 to facilitate this, with all necessary staff now having received the training.				
37			The Trust to implement an integrated electronic patient record system by September 2017.	Executive Director of Health Informatics	Deputy Director of Health Informatics	01/09/2017	The Trust commenced a review of its current clinical information systems in 2014 and the RDaSH Board of Directors approved an outline business case which identified investment for the procurement and implementation of a new system during 2016 to go live on 1 October 2017. A clinically led group of RDaSH staff developed an output based specification (OBS) document that detailed what clinical staff need the new clinical system to deliver in order to provide an integrated patient record that will provide a single view of patients across the Trust to assist the delivery of good quality patient care. The formal procurement process to identify an appropriate clinical information system provider commenced in February 2016. The Trust created a Core Clinical Evaluation Team made up of mainly clinical staff representing services from across the Trust. This team provided a key role in identifying a preferred system supplier by evaluating and scoring supplier responses to the OBS, attending and reviewing supplier demonstrations and attending site visits to talk to other users of the systems. In June 2016 the Core Evaluation Team agreed a recommendation to the Board of Directors that TPP SystmOne should be the Trust preferred supplier. In July 2016 the Board accepted the recommendation, subject to contract negotiations. A Full Business Case and contract terms with TPP will be presented to the Board of Directors on 29 September 2016 for approval; this will conclude the procurement phase and commence the implementation phase of the project.				
38	12	The Trust must ensure that all people who use services have an up to date risk assessment and care plan, which accurately reflect their needs.	Team manager will identify the current position for those patients who do not have a current risk assessment.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Mental Health)	Assistant Director for Adult Mental Health / Care Group Directors for Rotherham / Doncaster / NL	31/01/2016	The team has identified patients who do not have a current risk assessment.	To further support this work, Internal Audit have undertaken an audit of current use and compliance with risk assessments across in-patients and community services. The report from this has now been	Theme: Record Keeping and Risk Assessment Links to Actions 2, 7, 8, 19 21, 33, 60 and 65.	Quality and Safety Sub-Committee Clinical Quality Review Group Business Division Clinical Governance Group Adult Mental Health Business Division Risk Register	

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39			All risk assessments to be completed.		Assistant Director for Adult Mental Health / Care Group Directors for Rotherham / Doncaster / NL	31/03/2016	Process for completing risk assessments has been agreed and implemented across the service. All Locality Managers receive a weekly report on the uptake of risk assessments and reviews completed by care coordinator. The care plan audit results demonstrate overall improvements in risk reviews in all teams.	received and the outcome will be combined with the risk assessment review currently being undertaken as part of Listening into Action and will form a focus of the next phase of the Trust's Quality Improvement Strategy.	Trust undertaking pilot of complexity tool to ensure targeted assessment and management of risk through Trust's Listening into Action movement Listening into Action Care Records Audit		
40			The Community Managers Group to develop and implement service specific care planning templates, both in electronic patient record and paper format, for each of the Trust community services.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Mental Health)	Assistant Director for Adult Mental Health / Care Group Directors for Rotherham / Doncaster / NL	08/02/2016	Membership and format of the Community Managers Group has been agreed.				
41				Chief Operating Officer (w/e/f 01/07/2016) Service Director (Mental Health)	Assistant Director for Adult Mental Health / Care Group Directors for Rotherham / Doncaster / NL	29/02/2016	The first meeting of the Community Managers Group will take place on 14/03/2016, chaired by the Service Director (Mental Health). The terms of reference will be presented for ratification at the meeting.				
42				Chief Operating Officer (w/e/f 01/07/2016) Service Director (Mental Health)	Assistant Director for Adult Mental Health / Care Group Directors for Rotherham / Doncaster / NL	31/03/2016	Each team has identified their present position and continue to review all risk assessments. This includes establishing the risk assessment and care planning requirements for each community service in both electronic and paper format.				
43				Chief Operating Officer (w/e/f 01/07/2016) Service Director (Mental Health)	Assistant Director for Adult Mental Health / Care Group Directors for Rotherham / Doncaster / NL	30/06/2016 extended to 30/11/2016 following Big Conversation meetings and identified need for broader pilot phase	Work to implement to embed agreed risk assessment and care planning templates with appropriate monitoring arrangements in place as agreed by the Community Managers Group is on-going. Meetings have taken place (Big Conversation and Themes and Trends Analysis) where it has been agreed that there are challenges with the existing risk assessment tool. This programme of work is now being progressed through a specific Listening into Action project, which has identified seven actions under the following headings: - Patient Complexity Risk Screening Tool to be reviewed and adjusted to ensure it is suitable for all services - Risk Management - Policy Review - Audit - Use of the term 'Recovery' - Central coordination - Electronic system review and planning These are currently in progress. Due to the level of engagement from clinicians across the Trust, the engagement phase has been extended with pilots scheduled to commence 1st November 2016. Following this pilot the tools will be reviewed and audited for efficacy, with a nurse and medical lead already identified to undertake this.				
44			Trust wide Care Records Audit to be completed during 2016/17 to monitor implementation of comprehensive risk assessments and reviews taking place.	Executive Director of Nursing and Quality	Assistant Director for Adult Mental Health / Care Group Directors for Rotherham / Doncaster / NL	30/09/2016	Trust Clinical Records Audit has now been completed. Results have been collated, analysed and populated into reports. The results for the Adult Mental Health Business Division's Community Services were an overall rating of 'good' and that in 90.9% of records 'e appropriate/agreed risk assessment tool [was] used' and an action plan has been developed to strive for continuous improvement.				
45	13	The Trust must ensure that medication management practices are in line with Trust policy and national guidance in relation to the storage, prescribing, administration and recording of medicines.	Review the Trust Safe & Secure Handling of Medicines policy in line with national guidance.	Executive Medical Director	Assistant Director for Adult Mental Health / Care Group Directors for Rotherham / Doncaster / NL	29/02/2016	Consultation on the Safe and Secure Handling of Medicines policy review has been undertaken. The policy was accepted by the Medicines Management Committee on 18/02/2016 and ratified by the Clinical Quality Group on 01/03/2016 and has subsequently been implemented into clinical practice.		Theme: Medicines Management Links with actions 6, 16, 17 and 45. Trust Pharmacy Strategy	Medicines Management Committee Business Division Medicines Management Group Business Division Clinical Governance Group Team Managers Meetings Adult Mental Health Business Division Risk Register	
46			Review medicines management forms used in the Assertive Outreach Team in line with Trust policy.	Executive Medical Director	Assistant Director for Adult Mental Health / Care Group Directors for Rotherham / Doncaster / NL	01/01/2016	Revised medicine management forms have been developed and implemented in the Assertive Outreach Team.				

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5	Ref	CQC Requirements	Action Agreed	Accountable Director	Accountable Assistant Director / Care Group Director	Timescale	Progress Comments	Leading the Way with Care	Golden Thread	Governance	Status
47			Develop and implement standard operating procedures for use across the adult mental health community services in line with Trust policy.	Executive Medical Director	Assistant Director for Adult Mental Health / Care Group Directors for Rotherham / Doncaster / NL	31/03/2016	Standard Operating Procedures and standardised recording sheets were approved by the Medicines Management Committee in March 2016. These cover prescribing, ordering, storing, administering/delivering and destruction of medicines in community teams. The pharmacy team has a rota for regular visits to all community services to audit adherence to Trust policy for safe storage of medicines.				
48	14	The Trust must ensure that the physical health needs of people who use services are assessed and monitored appropriately and this is evidenced in peoples care records.	Cross Business Division Physical Health and Wellbeing Strategy to be developed.	Executive Medical Director	Assistant Director for Adult Mental Health / Care Group Directors for Rotherham / Doncaster / NL	31/03/2016 extended to 31/10/2016 following discussion at Quality Committee on 14/07/2016	Trust Medical Director in collaboration with the Trust Physical Health and Wellbeing Lead and PH&WB Strategy Group is developing the Trust's Physical Health and Wellbeing Strategy in line with the Trust Quality Priority 2016/17: To enable the delivery of 'holistic, integrated physical and mental healthcare'. This was discussed at the Physical Health and Wellbeing Group on 12/07/2016 and subsequently submitted to the Quality Committee and Board of Directors for approval. A PH&WB Briefing Paper which has been approved by the Trust Board will form the basis of the PH&WB Strategy.		Links to CQC MHA Action #2 Physical Health and Wellbeing Strategy CQUIN	Clinical Quality Group Physical Health and Wellbeing Strategy Group Adult Mental Health Business Division Risk Register	
49			To hold monthly meetings to discuss physical health assessments.	Executive Medical Director		31/03/2016	Medical Director in collaboration with the Trust Physical Health and Wellbeing (PH&WB) Lead has reviewed the Physical Health and Wellbeing Group Terms of Reference and membership together with the Trust's Physical Health and Wellbeing Strategy in line with the Trust Quality Priority 2016/17: To enable the delivery of 'holistic, integrated physical and mental healthcare'. The most recent meeting was held on 15 September 2016 and focussed on: 1. The four main areas that form the focus of the strategy. 2. Outcome of the mapping exercise showing progress since 2009-2016. 3. Proposed structure of the Physical Health and Wellbeing Group in order to try and implement an action plan to continue the work that has taken place to date. 5. Review of the position in each business division. A PH&WB CQUIN Group (Adult Mental Health and OPMH Services) meets monthly, focusing on physical health assessments and the requirements of the national PH&WB CQUIN 2016/17. PH&WB clinics are being implemented across AMH community teams, staff are trained to undertake physical health checks.				
50			Implement physical health and wellbeing monitoring.	Executive Medical Director		31/12/2015	The ReThink adapted physical health and wellbeing tool is now in place across all community adult mental health services.				
51			Conduct Physical Health and Wellbeing clinics in all localities for the Early Intervention in Psychosis Service and as part of the Nurse Led Clinics.	Executive Medical Director		30/06/2016	The Trust has already introduced physical health and wellbeing clinics in Early Intervention and Psychosis services in all three localities. Physical Health and Wellbeing Nurse Led Clinics now implemented in all localities with the exception of Manchester where recruitment is currently underway.				
52			To develop the recording of Physical Health and Wellbeing.	Executive Medical Director	Assistant Director for Adult Mental Health / Care Group Directors for Rotherham / Doncaster / NL	30/09/2016	Paper recording was being completed until an electronic solution had been agreed with Silverlink. Silverlink has updated the electronic patient record to include the ReThink Physical Health and Wellbeing Assessment with effect from 12/07/2016. A user guide has been added to the Clinical Document intranet site for Silverlink users: http://nww.intranet.rdash.nhs.uk/support-services/health-informatics/clinical-systems-help-information/clinical-systems-documentation/				
53			Trust wide Care Records Audit to be completed during 2016/17.	Executive Director of Nursing and Quality	Assistant Director for Adult Mental Health / Care Group Directors for Rotherham / Doncaster / NL	30/09/2016	Trust Clinical Records Audit has now been completed. Results have been collated, analysed and populated into reports. The results for the Adult Mental Health Business Division's Community Services was an overall rating of 'good' and that in 97.1% of records 'patients [had] a holistic assessment carried out which includes an assessment of physical health and wellbeing needs' and an action plan has been developed to strive for continuous improvement.				

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5	Ref	CQC Requirements	Action Agreed	Accountable Director	Accountable Assistant Director / Care Group Director	Timescale	Progress Comments	Leading the Way with Care	Golden Thread	Governance	Status
54	**Long stay/rehabilitation mental health wards for working age adults**										
55	15	The Trust must ensure that all bags used for storing emergency equipment are well maintained and fit or the purpose of delivering equipment safely in an emergency situation.	Daily checks to continue to be undertaken in line with the Trust Resuscitation policy. Any breakages or tears to be reported immediately to the Resuscitation Officers.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Mental Health)	Assistant Director for Adult Mental Health / Care Group Directors for Rotherham / Doncaster / NL	30/11/2015	Emergency equipment bag replaced. A system is in place to undertake the checks in line with the Resuscitation policy. Compliance and non compliance is monitored and issues addressed via the Resuscitation Committee. Outstanding issues will be escalated to the Quality and Safety Sub Committee.	All emergency equipment bags in use across the organisation now replaced.	Links to action 41 and 76.	Resuscitation Committee Clinical Quality Group Quality and Safety Sub-Committee	
56			Daily checks monitored by Resuscitation Lead and reported to Resuscitation Committee.	Executive Director of Workforce and Organisational Development	Assistant Director for Adult Mental Health / Care Group Directors for Rotherham / Doncaster / NL	31/12/2015	Compliance and non compliance is already monitored and issues addressed via the Resuscitation Committee with most recent audit completed in September 2016. Outstanding issues are escalated to the Quality and Safety Sub Committee				
57	16	The Trust must ensure that staff check that all fridge thermometers record the highest and lowest temperatures daily, reset thermometers daily and record it to help ensure the safe storage of medication and reduce any adverse effects on patients of taking medication damaged by not being kept cold enough.	Daily checks to continue to be undertaken in line with the Trust Safe and Secure Handling of Medicines policy and monitored by the Medicines Management Committee.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Mental Health)	Assistant Director for Adult Mental Health / Care Group Directors for Rotherham / Doncaster / NL	31/12/2015	Daily checks undertaken by team managers and weekly reviews by modern matron.		Theme: Medicines Management Links with actions 6, 13, 17 and 45. Trust Pharmacy Strategy	Medicines Management Committee Business Division Medicines Management Group Business Division Clinical Governance Group Team Managers Meetings	
58			Pharmacy technicians to review temperature recording and report compliance to Medicines Management Committee.	Executive Medical Director	Assistant Director for Adult Mental Health / Care Group Directors for Rotherham / Doncaster / NL	31/12/2015	Fridge and room temperature recording is emphasised in Medicines Management training. A system is in place for pharmacy technician staff to review temperature recording at each ward visit and for compliance to be collated and reported to Medicines Management Committee.				
59	17	The Trust must ensure that medication is administered in accordance with prescription charts and that any reason for a dose not being administered is recorded at the time to show safe compliance with prescribed medication, reducing the risk of any adverse impact on the patient.	Ensure omitted/unsigned doses are regularly audited with monitoring through Medicines Management Committee	Executive Medical Director	Assistant Director for Adult Mental Health / Care Group Directors for Rotherham / Doncaster / NL	29/02/2016	Regular audit of omitted/unsigned doses incidents are reviewed through the medicines management audit programme. Compliance with the audit programme and subsequent action is monitored through the Medicines Management Committee. The structured audit will be repeated on a bi-annual basis. The audit tool is available for teams to use as required between the audit programme.		Theme: Medicines Management Links with actions 6, 13, 16 and 45. Trust Pharmacy Strategy	Medicines Management Committee Business Division Medicines Management Group Business Division Clinical Governance Group Team Managers Meetings	
60	18	The Trust must ensure that staff complete mandatory training to achieve its standard target of 90% and provide systems to record accurately which staff have been trained to help them maintain the necessary skills to provide safe care to patients.	The division to monitor mandatory/statutory training compliance by team and report any gaps to the Assistant Director.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Mental Health)	Assistant Director for Adult Mental Health / Care Group Directors for Rotherham / Doncaster / NL	31/03/2016 Action returned to amber following reduction in compliance in AMH Business Division. Revised target date 31/12/2016	The Learning and Development Team have been visiting each of the Business Divisions to support/check that the trained administrators have any further training needs met and they will also be tasked with checking that information is being input in to the system in a timely and consistent manner. The Learning and Development Team continue to inform Assistant Directors of those staff who are not compliant in each MAST requirement so their attendance can be prioritised. Administrators in each of the Business Divisions have been identified and trained to input mandatory training information/data on to the OLM system. Compliance with mandatory/statutory training has been sustained at 89-90% since February 2016. As at 31/08/2016 compliance in the Adult Mental Health Services Business Division was 83.86%. Monthly team figures produced for Assistant Director who identifies areas of concerns and highlights to relevant team managers.	Research, Education and Development (RED) Centre have worked additional hours, including evenings and weekends to ensure that sufficient training places are available across the organisation. RED Centre have piloted and implemented the option of a 'patient ready' induction across the Trust for services where it is most beneficial for staff to have completed all requisite training before patient contact. Trust has recently undertaken a Governance Review and has subsequently formed the People's Sub-Committee which is responsible for oversight of training compliance.	Theme: Mandatory and Statutory Training Links with Actions 18, 24, 28, 36, 52, 63, 66, 68 and 75.	People's Sub-Committee/Human Resources and Organisational Development Group Education and Training Forum Business Division Clinical Governance Group	

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5	Ref	CQC Requirements	Action Agreed	Accountable Director	Accountable Assistant Director / Care Group Director	Timescale	Progress Comments	Leading the Way with Care	Golden Thread	Governance	Status
61	**Specialist community mental health services for children and young people**										
62	19	The Trust must ensure that staff complete risk assessments and prepare complete care plans and keep them both up to date.	All Rotherham CAMHS records to be reviewed to ensure that all patients have complete risk assessments and care plans.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for CAMHS / Children's Care Group Director	31/01/2016	All Rotherham CAMHS staff have received a 1-1 with their line manager and safeguarding named nurse to review their records to ensure appropriate risk assessments and care plans are in place.	To ensure sustainability of this approach, further workshops have been planned which will focus on in house record keeping, incorporating the 'Signs of Safety' into the holistic record keeping model. These sessions will be followed up by sessions from Capsticks on the legal elements to consider. Silverlink has been updated to make inputting easier for clinicians as risk assessments now automatically populate with previous information that will remain current, so all historic information will populate into the relevant section. The service has developed a new Care Planning and Assessment window which supports clinicians with inputting which has now been submitted to Silverlink.	Theme: Record Keeping and Risk Assessment Links to Actions 2, 7 , 12, 60 and 65. Clinical Records Audit	Business Division/Care Group Clinical Governance Group Quality Visit from Rotherham CCG on 16 September 2016	
63				Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for CAMHS / Children's Care Group Director	30/09/2016	Training programme have been developed and delivered between April 2016 and September 2016. This initial programme focussed on supporting existing staff in maintaining and improving skills and new staff recruited as part of the transformation of service to deliver the implementation of the government policy of Future in Mind.				
64			Silverlink data quality portal developed to highlight care plan/risk assessment data quality issues to be implemented.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for CAMHS / Children's Care Group Director	18/01/2016	Silverlink data quality portal developed and implemented for clinicians to highlight where care plans and risk assessments or review date are missing.				
65			Audit the use of Silverlink data quality portal and identify appropriate actions.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for CAMHS / Children's Care Group Director	31/03/2016	A weekly task and finish group was established, including the operational services, the performance team and the data team to implement the action plan following the audit. Due to the progress made with the actions the frequency of the meetings has now been reduced. This workstream continues to be closely monitored by the Director of Finance and Chief Operating Officer.				
66	**Wards for older people with mental health problems**										
67	20	The Trust must ensure that staff have detailed comprehensive knowledge of Mental Capacity Act (MCA) and its application to ensure patients are cared for in accordance with the correct legal framework.	Existing Trust Plan to embed Mental Capacity Act and Deprivation of Liberty Safeguards (Dolls) to be reviewed and implemented. This will include all staff having appropriate knowledge and skills for MCA and DoLs and ensuring correct application.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Mental Health)	Assistant Director for Older People's Mental Health / Care Group Directors for Rotherham / Doncaster / NL	30/09/2015	Mental Capacity Act Action Plan produced and signed off by the Board of Directors in February 2016. All objectives relating to training have been completed and a framework for training developed, which was signed off by the Directors and Assistant Directors. A Training Needs Analysis (TNA) has been undertaken to identify the appropriate staff and training required. This was ratified at the Trust's Joint Management Meeting for discussion and agreement. The mental capacity training commenced in June 2016 and is being delivered by Yvonne Taylor, Mental Capacity Act lead and Richard Tucker, Mental Health Legislation trainer. A learning and development facilitator has also been identified to support with the training. The MCA training framework has been approved by the MHLC sub group, as follows: - MCA Level 1 Training Leaflet has been designed and has been introduced into the Trust induction from 01/04/2016. - MCA Level 2 training is available as an e-learning course and is included on ESR. - Half day training courses for managers have been scheduled throughout 2016/17 and are included in the Learning and Development Programme for 2016/17 The programmes are available within the Corporate Learning and Development Programme for staff to access and book onto available sessions. It is also advertised through the daily communications bulletin and information sent direct to senior managers. Now that the TNA and training programme has been agreed and the Trust is in the process of attaching competencies to individual staff training matrix on the Electronic Staff Record (ESR) system.	Mental Capacity Conference hosted by the Trust in April 2016 titled 'Making Legal Decisions'. Mental Capacity Act Forum established from September 2016.	Theme: Consent and Mental Capacity Links to Actions 37 and 53 and 26 Links to CQC MHA Action #1, #3, #7 and #11	Mental Health Legislation Committee Business Division Clinical Governance Group	
68											
69											
70			The MCA Lead to provide direct support and guidance to staff within Older People's Mental Health Services on a daily basis to ensure staff are supported in the delivery of MCA.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Mental Health)	Assistant Director for Older People's Mental Health / Care Group Directors for Rotherham / Doncaster / NL	31/01/2016	Older People's Mental Health services staff are continuing to contact the MCA Lead directly for advice and guidance as required.				

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5	Ref	CQC Requirements	Action Agreed	Accountable Director	Accountable Assistant Director / Care Group Director	Timescale	Progress Comments	Leading the Way with Care	Golden Thread	Governance	Status
71			Immediate training will be delivered to relevant staff in Older People's Mental Health Services as a consequence of the direct support provided.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Mental Health)	Assistant Director for Older People's Mental Health / Care Group Directors for Rotherham / Doncaster / NL	29/02/2016	Training is provided by the Trust Mental Capacity Act (MCA) Lead in response to contacts from clinical staff.				
72			MCA Lead to analyse the training needs required in order to influence mandatory/statutory training needs.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Mental Health)	Assistant Director for Older People's Mental Health / Care Group Directors for Rotherham / Doncaster / NL	31/03/2016	The MCA training framework has been approved by the MHLC sub group. - MCA Level 1 Training Leaflet has been designed and has been introduced into the Trust induction from 01/04/2016. - MCA Level 2 training is available as an e-learning course and is included on ESR. - Half day training courses for managers have been scheduled throughout 2016/17 and are included in the Learning and Development Programme for 2016/17.				
73	21	The Trust must ensure that daily nursing notes reflect the care and treatment of patients to ensure care is being delivered in accordance with care plans and risk assessments.	Modern matrons and ward managers are reviewing nursing notes daily to ensure they reflect care plans and risk assessments.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Mental Health)	Assistant Director for Older People's Mental Health / Care Group Directors for Rotherham / Doncaster / NL	31/01/2016	Ward managers are undertook daily sample audit of nursing notes for 5 patients per ward between January and September 2016 to ensure that the nursing notes reflect the care and treatment of patients to ensure that care is being delivered in accordance to care plans and risk assessments. Following evidenced improvement in the Care Records Audit results issued in September 2016, the frequency of these audits has been reduced to weekly. Any areas for action are overseen by the Ward Managers and a summary of the outcomes is sent to the Modern Matron and Assistant Director.		Theme: Record Keeping Links to Actions 8, 12, 21 and 33.	Business Division Clinical Governance Group	
74			Matrons to undertake case note audit to review improvements and ensure record keeping training reflects issues identified.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Mental Health)	Assistant Director for Older People's Mental Health / Care Group Directors for Rotherham / Doncaster / NL	29/02/2016	Modern Matrons continue to undertake case note audits of daily nursing notes to ensure they reflect care and treatment of patients.				
75			Older People's Mental Health Service to implement the inpatient record keeping training program to ensure compliance with Trust record keeping standards.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Mental Health)	Assistant Director for Older People's Mental Health / Care Group Directors for Rotherham / Doncaster / NL	30/04/2016	Bespoke training delivered to staff where it was identified that there was a gap in knowledge or training not previously delivered. This is now being sustained through clinical supervision with individuals where care records are routinely reviewed.				
76			Trust wide Care Records Audit to be completed during 2016/17.	Executive Director of Nursing and Quality	Assistant Director for Older People's Mental Health / Care Group Directors for Rotherham / Doncaster / NL	30/09/2016	Trust Clinical Records Audit has now been completed. Results have been collated, analysed and populated into reports. The results for Older People's Mental Health Inpatient Services were an overall rating of 'good' and that in 100% of records 'a patient's care plan(s) [was] reviewed for effectiveness within specified timescales' and an action plan has been developed to strive for continuous improvement.				
77	**Community health services for adults**										
78	22	The Trust must ensure there are sufficient staff to meet the patients need within the community nursing service.	Daily review of workload by clinical manager/team leader will be undertaken to ensure safe staffing by shift.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for DCIS / Doncaster Care Group Director	01/01/2016	The service continues to review the required workload and compares this with available workforce on a daily basis. If required, Team Leaders move nursing staff across Doncaster to meet peaks in demand. If workload is significantly higher than available workforce this is escalated to the Divisional Management Team who instigate Business Continuity Procedures and reallocate nursing staff from other roles to work in the community to meet demand.	Area Clinical Managers are participating in the national Community Nursing Workshops hosted by the Queens Nursing Institute and the King's Fund. Trust is engaging with local universities to attract preceptorship nurses into the organisation when they have completed their degree course. This has included presenting stands and university fayres. The service has commenced analysis of IR1s when compared to staffing levels to triangulate the prevalence of incidents with capacity and demand. Service is completing analysis and triangulation of Exit Questionnaire responses with an aim of improving retention of staff rates.	Links to Actions 1, 50, 59 and 70. Nurse Recruitment Strategy	People's Sub-Committee Business Division Clinical Governance Group Risk Register	
79			A monthly review of capacity and demand data will be undertaken. This will ensure that staff are allocated across localities appropriately to ensure staffing levels are safe.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for DCIS / Doncaster Care Group Director	31/01/2016	A system is in place to review and analyse capacity and demand on a monthly basis within the Trust and with relevant commissioners.				
80			A review of roles and responsibilities within teams is to be undertaken to ensure that the skill mix is appropriate.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for DCIS / Doncaster Care Group Director	29/02/2016	Community nursing service skill mix and roles have been reviewed. The review has resulted in the development and roll out of a new Healthcare Assistant Development Programme in order to upskill staff to support the workload of the qualified nurses. All staff completed the Programme by the end of March 2016.				

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5	Ref	CQC Requirements	Action Agreed	Accountable Director	Accountable Assistant Director / Care Group Director	Timescale	Progress Comments	Leading the Way with Care	Golden Thread	Governance	Status
81			Management of sickness absence. All managers to review every single case of sickness absence to ensure that it is being managed in line with Trust policy.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for DCIS / Doncaster Care Group Director	29/02/2016	All sickness absence in community nursing has been reviewed jointly with human resources. All staff who have met the threshold contained in the Trust's Management of Sickness Absence Policy are being monitored. Sickness hearings continue to be undertaken and support provided to staff via Occupational Health and adjustments made where appropriate. The Trust has also implemented a system to highlight the teams with the 'Top 10' highest sickness absence in the Trust at any one time to review the position and ensure sufficient support is in place for managers who are following the process.				
82			Develop recruitment and retention plan with Workforce & Organisational Development and Nursing and Quality.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for DCIS / Doncaster Care Group Director	29/02/2016	A Nurse Recruitment Strategy has been developed by members of the Executive Management Team and DCIS Adults to support targeted recruitment in community nursing. Vacancy rates are monitored monthly via the Trust's People's Sub-Committee.				
83			Introduction of e rostering within community services to support the allocation of staff.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for DCIS / Doncaster Care Group Director	31/07/2016	E-rostering now rolled out for all Community Nursing both planned and unplanned are rolled out as well as Call Handling.				
84	23	The Trust must ensure that staff complete venous thromboembolism risk assessments on all patients admitted and that compliance is monitored as part of the safety thermometer measures of safety.	The Trust to implement NICE Guidance in relation to all admissions including those transferred from acute providers.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for DCIS / Doncaster Care Group Director	31/12/2015	Review of NICE Guidance completed by Modern Matron. All patients now assessed on admission or transfer for VTE.	Documentation updated to include more prompts on VTE assessment, for example, when telephone referral is made this is included as a question on referral form completed by call handler.	NICE Guidance Clinical Audit Programme 2016/17	Business Division Clinical Governance Group	
85				Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for DCIS / Doncaster Care Group Director	29/02/2016	Compliance with the NICE Guidance is included in the revision of the Trust VTE policy. This policy was approved by the Trust Clinical Quality Group on 02/02/2016.				
86			Record VTE as part of monthly Patient Safety Thermometer.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for DCIS / Doncaster Care Group Director	15/01/2016	VTE is recorded monthly as part of Patient Safety Thermometer submission and submitted as part of the national dataset.				
87			All relevant staff will be trained in line with appropriate Trust processes and procedures.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for DCIS / Doncaster Care Group Director	31/01/2016	Staff training commenced in October 2015 via e-learning. All staff have completed the training, with the exception of those off sick, who will complete the training on their return to work. GP input into VTE assessment is being revised via service level agreement.				
88			Monitor compliance through audit of assessment and records against Trust process and procedures.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for DCIS / Doncaster Care Group Director	31/03/2016	Spot-checks have been undertaken and identified that the new approach is being implemented. Further areas for improvement for recognising and recording the risk and assessment for VTE have also been identified. Changes have been made to the documentation and implemented in the services.				
89				Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for DCIS / Doncaster Care Group Director	30/06/2016	Audit completed as part of the Trust Clinical Audit Programme 2016/17, report has now been drafted and is with the Modern Matron for review. Monthly spot checks are being undertaken on all ward areas. No concerns have been reported and compliance is reviewed at the monthly Clinical Governance & Assurance Meeting.				
90	**Trust wide Mandatory Training**										

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5	Ref	CQC Requirements	Action Agreed	Accountable Director	Accountable Assistant Director / Care Group Director	Timescale	Progress Comments	Leading the Way with Care	Golden Thread	Governance	Status
91	24	The Trust must ensure that there is an effective system to ensure that staff are up to date with mandatory training.	The Trust has agreed a minimum mandatory /statutory training compliance target of 90% to be achieved by 31 December 2015.	Executive Director of Workforce and Organisational Development	Assistant Directors / Care Group Directors	31/12/2015	The Trust Mandatory/Statutory training compliance improvement journey is detailed as follows: 1 April 2015 62.12% 1 July 2015 65.24% 1 October 2015 83.77% 1 January 2016 88.06% 1 February 2016 88.89% 16 March 2016 90.28% 30 April 2016 89.66% 30 May 2016 89.82% 30 June 2016 89.65% 30 July 2016 89.84% Therefore, when rounded, the Trust achieved the 90% target in February 2016 and has since sustained this level of compliance.	Research, Education and Development (RED) Centre have worked additional hours, including evenings and weekends to ensure that sufficient training places are available across the organisation. RED Centre have piloted and implemented the option of a 'patient ready' induction across the Trust for services where it is most beneficial for staff to have completed all requisite training before patient contact. Trust has recently undertaken a Governance Review and has subsequently formed the People's Sub-Committee which is responsible for oversight of training compliance.	Theme: Mandatory and Statutory Training Links with Actions 18, 24, 28, 36, 52, 63, 66, 68 and 75.	People's Sub-Committee/Human Resources and Organisational Development Group Education and Training Forum Business Division Clinical Governance Group	
92			The Trust will continue to monitor mandatory/statutory training compliance.	Executive Director of Workforce and Organisational Development	Assistant Directors / Care Group Directors	31/12/2015	A robust system of monitoring is in place. This includes live daily monitoring by the Research Education and Development (RED) Centre and the Executive Director of Workforce and Organisational Development is informed daily of the compliance level. The Trust is able to monitor compliance by individual, team, Business Division and Trust wide. A report is provided monthly which identifies those staff who are no longer compliant in any of their mandatory or statutory (M&S) training requirements by team. This is shared with the relevant Assistant Director to address with their managers/teams within their Business Division and these staff are prioritised for training. A report is presented to the HR & OD group every month, highlighting each Business Division's current position for each of the M&S training programmes as at the end of the preceding month. This is reviewed and assurance sought with regard to actions being taken by each Assistant Director who also attend the meeting. Specific topics and staff groups where compliance is lower than the accepted percentage and particular improvement is required, continue to be targeted individually. All courses with dates and target audience are advertised in the Learning and Development programme and through the daily communications bulletin. Where there are available places on courses these are also advertised through the daily bulletin.				
93	**Trust wide Duty of Candour**										
94	25	The Trust must ensure that staff identify and manage incidents triggering the duty of candour. The Trust must ensure that verbal and written apologies are made to the relevant people and recorded in line with the Trust's responsibilities under the duty of candour.	Executive Management Team to approve the revised serious incident policy and incident reporting policy, which include the threshold and criteria for triggering the Duty of Candour.	Executive Director of Nursing and Quality	Assistant Directors / Care Group Directors	31/03/2016	The reviewed Serious Incident policy was accepted by the Risk Management Sub-Group on 17/02/2016. The Serious Incident Policy and Incident Reporting Policy with final amendments were subsequently sent to the Service Directors for comments and sharing at the Operational Managers Meeting (OMM). Final versions were approved by the Quality Committee on 14/04/2016.	Duty of Candour webpages on staff intranet updated to provision additional guidance and support. Trust sought advice from leading legal firm on the application of the Duty of Candour to ensure robust processes are implemented.	Theme: Duty of Candour	Quality Committee Quality and Safety Sub-Committee Operational Management Meeting	
95			Align the "Being Open" and "Duty of Candour" processes to enable staff to identify and manage incidents triggering Duty of Candour.	Executive Director of Nursing and Quality	Assistant Directors / Care Group Directors	31/03/2016	The aligned "Being Open" and "Duty of Candour" processes have been discussed and agreed with Service Directors and Assistant Directors at OMM on 04/03/2016 and 18/03/2016. The Trust's Being Open and Duty of Candour Policy and Duty of Candour Training Package has subsequently been updated to reflect this.				
96			Create a flow chart and harm categorisation chart to support staff in managing Duty of Candour.	Executive Director of Nursing and Quality	Assistant Directors / Care Group Directors	31/03/2016	Flow chart and harm categorisation chart have been completed and agreed with OMM on 04/03/2016 and 18/03/2016. These have subsequently been included in the Serious Incident and Incident Reporting Policy.				
97			Provide information and education to all professionally qualified staff through the development of an information leaflet and additional updated Duty of Candour training sessions.	Executive Director of Nursing and Quality	Assistant Directors / Care Group Directors	31/03/2016	Training has been modified to represent and emphasise the incident moderation flow. Updating training is an iterative process in order to ensure response to feedback from staff and national developments are incorporated into the package. The Duty of Candour leaflet for staff has been revised. Template letters produced to guide staff when sending letters in accordance with the Duty of Candour.				

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5	Ref	CQC Requirements	Action Agreed	Accountable Director	Accountable Assistant Director / Care Group Director	Timescale	Progress Comments	Leading the Way with Care	Golden Thread	Governance	Status
98			The Trust will liaise with the "incident management system provider" to update the incident reporting system to allow clinical managers to identify incidents that meet the Duty of Candour threshold.	Executive Director of Nursing and Quality	Assistant Directors / Care Group Directors	31/03/2016	The "incident management system provider" has updated the system to allow managers to declare an incident for Duty of Candour.				
99			The embedding of the Duty of Candour Policy will ensure that verbal and written apologies are made to the relevant people and recorded.	Executive Director of Nursing and Quality	Assistant Directors / Care Group Directors	31/03/2016 extended to 31/07/2016 by Quality Committee	Training sessions are available for staff and telephone support is provided by the Corporate Patient Safety Team. Embedding of the Duty of Candour Policy was a focus at the Trust's Operational Management Meeting on 04/03/2016, 18/03/2016 and 22/04/2016. In June 2016 extensive data, containing details on each incident that has triggered the Duty of Candour, including what is required to ensure the incident complies with the Duty, was sent to Business Divisions for action, with support from the Corporate Patient Safety Team. Assistant Directors were asked that all historical Duty of Candour cases must be closed by 31/07/2016 and this has now been completed (exception for Serious Incidents which follow the Serious Incident Process Timeframe). A monthly report on Duty of Candour compliance is presented at the Quality and Safety Sub-Committee and sent to all Assistant Directors for action.				
100			Trust wide internal audit to establish Trust compliance with Duty of Candour will be undertaken.	Executive Director of Nursing and Quality	Assistant Directors / Care Group Directors	30/09/2016	Phase 1 of the internal audit has been completed to determine the most effective methods of strengthening the Trust Duty of Candour process. Phase 2 of the audit is now in progress and the Trust is awaiting the results of this before progressing with any necessary actions.				

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5	Ref	CQC Requirements	Action Agreed	Accountable Director	Accountable Assistant Director / Care Group Director	Timescale	Progress Comments	Leading the Way with Care	Golden Thread	Governance	Status
101							**Actions that Trust SHOULD take to Improve:**				
102	**Community mental health services for people with learning disabilities and autism**										
103	26	The Trust should ensure that care records reflect people's capacity to make decisions where mental capacity is in question.	All Learning Disability Business Division Team Managers to meet with Trust MCA Lead to discuss best practice in this area.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for LD and Forensics / Care Group Directors for Rotherham / Doncaster / NL	31/01/2016	The Trust Mental Capacity Act Lead has met with all Service/Team Managers as follows: - Doncaster Service Manager on 19/10/2015. - North Lincolnshire Community Team on 19/01/2016 - Rotherham Community Team on 02/02/2016 and 03/05/2016. Subsequently MCA Lead is working jointly with service on complex cases relating to mental capacity. Service continues to work closely with MCA Lead in all localities, including receipt of training from MCA Lead and use of tools recently developed to guide staff and clinical supervision through issues relating to mental capacity. Examples of changes made include updates to referrals forms. Business Division continues to engage in Mental Capacity Act training programme. A Trust MCA Forum has been established, the first meeting will be held on 30 September and the learning disabilities services will engage in this forum once meetings are underway. Mental Capacity is now included in the Trust induction and a training leaflet has been issued to all staff in the organisation.	MCA Lead is working jointly with Learning Disabilities Business Division to develop a Standard Operating Procedure for Taking Blood when People do not have Capacity to Consent. Community Teams have a number of people who are trained as Best Interests Assessors. Mental Capacity Conference hosted by the Trust in April 2016 titled 'Making Legal Decisions'. Mental Capacity Act Forum established from September 2016.	Theme: Consent and Mental Capacity Links to Actions 37 and 53 and 20 Links to CQC MHA Action #1, #3 and #7	Quality and Safety Sub-Committee/Clinical Governance Group	
104			Review the templates on TPP to create a 'Legal Status Assessment' page in the Nurse Assessment. This will contain information relating to Mental Capacity to ensure that this is clearer on the system.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for LD and Forensics / Care Group Directors for Rotherham / Doncaster / NL	31/03/2016	A revised version of the template was trialled across all three localities. The final template was loaded on to the electronic system and went live on 11/04/2016. Revised template continues to be utilised across all teams and first review of effectiveness undertaken at May 2016 Records Group, where it was confirmed that the template is working well in all areas, with a reduction in the amount of fields to be populated and reduced duplication due to some fields now being 'questionnaires' and opposed to documents.	Assessment on TPP has been comprehensively reviewed and updated to make this more user friendly for Clinical staff.	Theme: Consent and Mental Capacity Links to Actions 37 and 53 and 20 Links to CQC MHA Action #1, #3 and #7	Quality and Safety Sub-Committee/Clinical Governance Group	
105	27	The Trust should ensure that care records are regularly reviewed and up to date.	Audit of care records to be undertaken to identify all records due for review. Review of these records to be prioritised in all services.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for LD and Forensics / Care Group Directors for Rotherham / Doncaster / NL	31/03/2016	Team Managers completed an audit of record review dates in February 2016 and have embedded this approach through reviewing records as part of Clinical Supervision. This has also been incorporated into the Standard Template for Clinical Supervision. Trust Clinical Records Audit has now commenced with data collection completed by 14 July 2016. Results are current being collated, analysed and populated into reports. The initial results for the Learning Disabilities Business Division are that in 81% of cases 'patient's care plan(s) was reviewed for effectiveness within specified timescales'. An action plan has been developed to strive for continuous improvement.	Business Division Records Sub-Group established from February 2016.	Theme: Record Keeping Links to Actions 8, 12, 21 and 33.	Clinical Quality Review Group Business Division Records Sub-Group	
106			Check and Challenge' visits to be undertaken to all community teams.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for LD and Forensics / Care Group Directors for Rotherham / Doncaster / NL	31/03/2016	Check and Challenge visit undertaken to Ironstone Centre on 08/12/2015, where no further actions were identified. Check and Challenge visit undertaken to Onyx Centre, Doncaster on 09/02/2016 where no further actions were identified. Check and Challenge visit undertaken to 220 Badsley Moor Lane, Rotherham on 16/02/2016, where no further actions were identified.				
107			Implement monitoring system into business division governance arrangements to ensure that improvements are sustained.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for LD and Forensics / Care Group Directors for Rotherham / Doncaster / NL	31/03/2016	Monitoring of the review of care records has been incorporated into the Terms of Reference for the recently introduced Business Division Records Sub-Group. This is a standing agenda item at the meeting and the baseline position from the Trust Care Records Audit is awaited. The Trust Care Records Audit completed on 14 July 2016. The Service is currently awaiting the results of the audit, which will provide the baseline position for on-going monitoring within the business division.				

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5	Ref	CQC Requirements	Action Agreed	Accountable Director	Accountable Assistant Director / Care Group Director	Timescale	Progress Comments	Leading the Way with Care	Golden Thread	Governance	Status
108	28	The Trust should ensure that Mental Health Act training is provided to all appropriate staff.	Implement Mental Capacity Act / Mental Health Act Training matrix within the business division. Monitoring to take place through HR&OD Group (now People's Sub-Committee)	Executive Director of Workforce & Organisational Development	Assistant Director for LD and Forensics / Care Group Directors for Rotherham / Doncaster / NL	31/03/2016	All objectives have been completed and a framework for training developed, which was signed off by the Directors and Assistant Directors. A Training Needs Analysis (TNA) has been undertaken to identify the appropriate staff and training required. This was ratified at the Trust's Joint Management Meeting for discussion and agreement. The mental capacity training commenced in June 2016 and is being delivered by Yvonne Taylor, Mental Capacity Act lead and Richard Tucker, Mental Health Legislation trainer. A learning and development facilitator has also been identified to support with the training. Mental Health Legislation Training has been arranged to be delivered from April 2016. A leaflet has been developed for Mental Health Awareness level1 and awaiting ratification. Once the leaflet has been issued to all staff compliance will be 100%. New starters into the organisation will receive this information on the first day of their induction. The programmes are available within the Corporate Learning and Development Programme for staff to access and book onto available sessions. It is also advertised through the daily communications bulletin and information sent direct to senior managers. Now that the TNA and training programme has been agreed and the Trust is in the process of attaching competencies to individual staff training matrix on the Electronic Staff Record (ESR) system.	Mental Capacity Act Forum established from September 2016.	Theme: Mandatory and Statutory Training Links to CQC MHA Action #9	People's Sub-Committee/Human Resources and Organisational Development Group Education and Training Forum Mental Health Legislation Committee	
109	**Domiciliary Care Service**										
110	29	The Trust should review medication management in regards to improvement in monitoring and more personalised storage for some people.	Review medication management systems for all service users in the Supported Living (Domiciliary Care) service.	Executive Medical Director	Assistant Director for LD and Forensics / Care Group Directors for Rotherham / Doncaster / NL	31/03/2016	All service users in the supported living (domiciliary care) service have received a medicines management review, which has been recorded in their care records. Actions and governance processes in relation to storage and monitoring of medications have been implemented.			Business Division Clinical Governance Group	
111	**Substance Misuse Services**										
112	30	The Trust must ensure that a female - only lounge is available at all times in the inpatient detoxification service.	An area will be identified as the female -only lounge at the New Beginnings inpatient detoxification service.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for Drugs and Alcohol / Doncaster Care Group Director	31/01/2016	A female only lounge has now been identified and this is also appropriately signed to ensure that service users are aware of where it is and its purpose. This room has also been redecorated recently. En-suite accommodation is available to comply with mixed sex guidelines, including in-room TV's. The unit has adopted the Trust eliminating mixed sex accommodation (EMSA) flowchart process. Additional CCTV coverage and associated signage has been added to cover communal areas.	The service now also has a designated Family Room to ensure that service users and their relatives have a quiet space where they can meet together on the unit. The service is managing rotas to ensure that when there are female patients accessing the service there is also a female member of staff on duty. Deputy Director of Nursing and Quality visited the service on 12 January 2016.	Links to Action 39.	Board of Directors Quality Committee Executive Management Team Quality and Safety Sub-Committee/Clinical Governance Group Business Division Clinical Governance Group	
113	31	The Trust should ensure that complaints procedures are accessible to all service users.	Display complaints procedure and Your Opinion Counts process in substance misuse services.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for Drugs and Alcohol / Care Group Directors for Rotherham / Doncaster	31/12/2015	The Trust's complaints procedure and Your Opinion Counts process is displayed in the reception area of each service base and included in relevant patient literature.	Service has implemented 'Aspire Live Chat' where services users can submit queries or feedback. Service is trialling 'HappyorNot' terminal in one of the bases which captures live feedback on service user experience and allows identification of themes and trends in service user experience.		Business Division Clinical Governance Group	
114	32	The Trust should ensure that they are following guidance on the facilitated access to mutual aid and support people to overcome their dependency.	Information on mutual aid to be displayed in all service patient waiting areas and routinely discussed with service users as part of care planning and review.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for Drugs and Alcohol / Care Group Directors for Rotherham / Doncaster	31/03/2016	Staff have been briefed to ensure that mutual aid involvement is recorded in the relevant section of NDTMS. This has been followed up by communication from Team Leaders.	The service offers venues and facilities to mutual aid groups to facilitate these to be held for service users. The service run a Support for Change Group to support service		Business Division Clinical Governance Group	

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5	Ref	CQC Requirements	Action Agreed	Accountable Director	Accountable Assistant Director / Care Group Director	Timescale	Progress Comments	Leading the Way with Care	Golden Thread	Governance	Status
115				Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for Drugs and Alcohol / Care Group Directors for Rotherham / Doncaster	31/03/2016	All service and team managers have reviewed the display of information of mutual aid materials within their services. Information is available in all service reception/waiting areas and is routinely discussed with service users.	user's family members that are support a family member through drug and alcohol problems. The service is currently offering training sessions to professionals from across disciplines and organisations on a number of topics including: - Interventions, helping family and difficult people - Mentoring, volunteering and supporting people - Services, pathways and interventions available			
116	33	The Trust should ensure that effective audit systems are used across the division in relation to care records.	All Drug and Alcohol records to be reviewed to ensure that all patients have complete and effective care plans.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for Drugs and Alcohol / Care Group Directors	29/02/2016	All Drug and Alcohol staff have received 1-1 s with their line manager to review their records to ensure appropriate care plans are in place. Training needs identified during 1-1s have been addressed and care plans are saved on the system. Reports have been designed on SystmOne which show all records that do not have a FACE Risk Assessment or Care Plan that has not been updated within the last three months and these are discussed with the relevant case worker.	New Beginnings staff have developed revised, holistic and recovery focussed care plan template. This has been uploaded onto SystmOne and is much more user friendly and easier for staff to complete.	Theme: Record Keeping Links to Actions 3, 8, 12, and 21 Care Records Audit	Quality and Safety Sub-Committee Clinical Quality Review Group Business Division Clinical Governance Group	
117			Drug and Alcohol services participate in the Trust's annual Care Records Audit.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for Drugs and Alcohol / Care Group Directors	30/09/2016	Trust Clinical Records Audit has been undertaken with data collection completed by 14 July 2016. Results are current being collated, analysed and populated into reports. The initial results for the Drug and Alcohol Business Division are an overall rating of 'good' with scores of over 80% in both the risk assessment and care planning criteria.				
118			Internal Audit Plan Quarter 2 2016-17 Records Management (Community Based) to be completed as part of a wider patient safety/lessons learned audit.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for Drugs and Alcohol / Care Group Directors for Rotherham / Doncaster	30/09/2016	Internal Audit has now completed a wider audit of risk assessments across a sample of patient records and the report has recently been received by the Trust. This outcome of this will be combined with the risk assessment review currently being undertaken as part of Listening into Action and will form a focus of the next phase of the Trust's Quality Improvement Strategy.				
119	**Acute wards for adults of working age and psychiatric intensive care units**										
120	34	The Trust should ensure that managers undertake routine audits to monitor compliance with the Trust seclusion policy and take action if staff are failing to follow required procedures.	Review Trust Seclusion Policy and undertake monitoring of procedures in line with the policy.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Mental Health)	Assistant Director for Adult Mental Health / Care Group Directors for Rotherham / Doncaster / NL	31/03/2016	The reviewed Trust Seclusion Policy was ratified by the Clinical Quality Group on 01/03/2016. Audits of compliance with procedures are monitored by the Mental Health Legislation Committee and the Medicines Management Committee, and actions to improve compliance are agreed and implemented. Discussed at Business Division Governance Meeting, where it was also confirmed that the updated seclusion booklet has been forwarded to CQC. Teaching sessions for ward staff and medical staff have been delivered in all four areas that have seclusion rooms. Discussions have also been held with consultant psychiatrists and junior doctors. Modern Matrons undertake regular audits of compliance with the Seclusion Policy.		Links to Actions 42, 43, 44 and 72	Mental Health Legislation Committee Medicines Management Committee Business Division Clinical Governance Group	
121	35	The Trust should consider installing mirrors to reduce blind spots in the main corridors of the acute admissions wards and the bedroom of the Mulberry plus area.	Environmental risk assessment to be undertaken and action to be taken to address identified recommendations	Executive Director of Nursing and Quality	Assistant Director for Adult Mental Health / Care Group Directors for Rotherham / Doncaster / NL	31/03/2016	Assistant Director and area/building manager have completed the required risk assessment. Following the risk assessment mirrors were ordered for the main corridors in the North Lincolnshire and Doncaster inpatient services and mirrors have now been fitted in all services.			Business Division Clinical Governance Group	

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5	Ref	CQC Requirements	Action Agreed	Accountable Director	Accountable Assistant Director / Care Group Director	Timescale	Progress Comments	Leading the Way with Care	Golden Thread	Governance	Status
122	36	The Trust should continue with the plan to ensure compliance with mandatory training across the inpatient wards, particularly to tackle low compliance with training on safeguarding of people from abuse and management of violence and aggression.	The Trust has agreed a minimum mandatory / statutory training compliance target of 90% to be achieved by 31 December 2015. Links to Trust wide Mandatory/Statutory Training Risk. Continue to implement reducing restrictive intervention action plan, including policy support being withdrawn.	Executive Director of Workforce and Organisational Development	Assistant Director for Adult Mental Health / Care Group Directors for Rotherham / Doncaster / NL	31/03/2016	The Learning and Development Team have been visiting each of the Business Divisions to support/check that the trained administrators have any further training needs met and they will also be tasked with checking that information is being input in to the system in a timely and consistent manner. The Learning and Development Team continue to inform Assistant Directors of those staff who are not compliant in each MAST requirement so their attendance can be prioritised. Administrators in each of the Business Divisions have been identified and trained to input mandatory training information/data on to the OLM system. Trust-wide compliance with mandatory/statutory training has been sustained at 89-90% since February 2016. As at 31/08/2016 compliance in the Adult Mental Health Services Business Division was 83.86%. Monthly team figures produced for Assistant Director who identifies areas of concerns and highlights to relevant team managers. Training sessions for reducing restrictive interventions (RRI) have been increased this year to meet the demands/needs of the service and included conflict resolution training for staff who do not require higher levels of training.	Research, Education and Development (RED) Centre have worked additional hours, including evenings and weekends to ensure that sufficient training places are available across the organisation. RED Centre have piloted and implemented the option of a 'patient ready' induction across the Trust for services where it is most beneficial for staff to have completed all requisite training before patient contact. Trust has recently undertaken a Governance Review and has subsequently formed the People's Sub-Committee which is responsible for oversight of training compliance.	Theme: Mandatory and Statutory Training Links with Actions 18, 24, 28, 36, 52, 63, 66, 68 and 75.	People's Sub-Committee/Human Resources and Organisational Development Group Education and Training Forum Business Division Clinical Governance Group	
123 124 125	37	The Trust should ensure that consent to treatment is being recorded in all care records.	Continue to implement recommendations from annual Trust care records audit. Existing Trust Plan to embed Mental Capacity Act and Deprivation of Liberty Safeguards (DoLs) to be reviewed and implemented. This will include all staff having appropriate knowledge and skills for MCA and DoLs and ensuring correct application.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Mental Health)	Assistant Director for Adult Mental Health / Care Group Directors for Rotherham / Doncaster / NL	30/09/2015	Mental Capacity Act Action Plan produced and signed off by the Board of Directors in February 2016. All objectives relating to training have been completed and a framework for training developed, which was signed off by the Directors and Assistant Directors. A Training Needs Analysis (TNA) has been undertaken to identify the appropriate staff and training required. This was ratified at the Trust's Joint Management Meeting for discussion and agreement. The mental capacity training commenced in June 2016 and is being delivered by Yvonne Taylor, Mental Capacity Act lead and Richard Tucker, Mental Health Legislation trainer. A learning and development facilitator has also been identified to support with the training. The MCA training framework has been approved by the MHLC sub group, as follows: - MCA Level 1 Training Leaflet has been designed and has been introduced into the Trust induction from 01/04/2016. - MCA Level 2 training is available as an e-learning course and is included on ESR. - Half day training courses for managers have been scheduled throughout 2016/17 and are included in the Learning and Development Programme for 2016/17 Records are also routinely audited by the Mental Health Act Office and the recording of consent is included within this audit.	Mental Capacity Conference hosted by the Trust in April 2016 titled 'Making Legal Decisions'. Mental Capacity Act Forum established from September 2016.	Links to Actions 20, 26 and 53. Links to CQC MHA Action #1, #3, #7 and #11	Locality Mental Health Legislation Group	
126	38	The Trust should ensure that Section 17 leave risk assessments are completed before patients take leave.	Review Section 17 Granting of Leave for inpatients standard operating procedure (SOP) for Adult Mental Health Services with clear instructions and guidance for staff regarding risk assessment documentation.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Mental Health)	Assistant Director for Adult Mental Health / Care Group Directors for Rotherham / Doncaster / NL	31/12/2015	Section 17 Granting of Leave Policy SOP was reviewed in December 2015 with clear instructions and guidance for staff regarding risk assessment documentation. This revised SOP now forms part of the inpatient leadership meetings in order to re-enforce good practice guidelines. Section 17 leave documentation is routinely audited by the Mental Health Act Office and also locally by the Modern Matrons for each inpatient service.			Mental Health Legislation Committee Locality Mental Health Legislation Groups Business Division Clinical Governance Group	
127	39	The Trust should ensure that there is access to female-only lounge areas for all wards.	Identify and ensure access to female only lounges on all wards.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Mental Health)	Assistant Director for Adult Mental Health / Care Group Directors for Rotherham / Doncaster / NL	31/03/2016	All wards have designated female-only lounges. Signage is also in place to ensure that female only lounges are clearly demarcated from other areas of the ward.		Links to Action 30	Safeguarding Quality and Standards Group Business Division Clinical Governance Group	

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5	Ref	CQC Requirements	Action Agreed	Accountable Director	Accountable Assistant Director / Care Group Director	Timescale	Progress Comments	Leading the Way with Care	Golden Thread	Governance	Status
128	40	The Trust should prioritise the roll-out of positive behaviour support plans for individuals who may be subject to restrictive practice such as restraint and seclusion.	Continue to implement the Trust Reducing Restrictive Interventions action plan, which includes the roll out of positive behaviour support plans, and monitor via the Restrictive Intervention Steering Group.	Executive Director of Nursing and Quality	Assistant Director for Adult Mental Health / Care Group Directors for Rotherham / Doncaster / NL	31/03/2016	The Reducing Restrictive Interventions Steering Group continues to meet bi-monthly to oversee the implementation of the Reducing Restrictive Interventions Action Plan which includes implementation of the use of positive behaviour support plans for people subject to potentially restrictive practices. The Group reports through the agreed governance processes.	In North Lincolnshire the local Learning Disabilities Team has recently supported the service to jointly develop a Positive Behaviour Support Plan for a service user with both mental health needs and learning disabilities.	Links to CQC MHA Action #13	Quality and Safety Sub-Committee Reducing Restrictive Interventions Group Business Division Clinical Governance Group	
129	41	The Trust should ensure that oxygen cylinders are securely stored in cylinder holders or an appropriate trolley.	Trust Resuscitation Officer to review storage of oxygen cylinders on inpatient wards.	Executive Director of Workforce and Organisational Development	Assistant Director for Adult Mental Health / Care Group Directors for Rotherham / Doncaster / NL	31/09/2015	Trust policy is that all large cylinders must be stored securely on a wheeled cradle in inpatient areas. Small cylinders are stored in resuscitation grab bags and are not required to be secured. Storage of cylinders is included as part of the weekly grab bag checks in line with the Trust Resuscitation Policy and monitored by the Resuscitation Committee. The Resuscitation Officer completes regular audits of oxygen cylinders on all inpatient wards, with the most recent of these undertaken during September 2016.	All emergency equipment bags in use across the organisation now replaced.	Links to Actions 15 and 76.	Resuscitation Committee Clinical Quality Group Quality and Safety Sub-Committee	
130	42	The Trust should repair the blinds in the seclusion rooms on Kingfisher wards and in Mulberry to improve natural light in these rooms and identify alternative arrangements to maintain privacy if the blinds are open	The blinds in the seclusion rooms on Kingfisher and Mulberry to be repaired.	Executive Director of Finance	Assistant Director for Adult Mental Health / Care Group Directors for Rotherham / NL	31/03/2016	Installation of a window and blind from BRITPLAS, a specialist company in the design of this type of window, has taken place.			Business Division Clinical Governance Group	
131	43	The Trust should change the lighting in the seclusion room on Kingfisher Ward to enable lights to be dimmed.	The lighting in the seclusion room on Kingfisher Ward to be reviewed.	Executive Director of Finance	Assistant Director for Adult Mental Health / Care Group Directors for Rotherham	31/03/2016	Lighting reviewed and new dimmable lighting has been installed.			Business Division Clinical Governance Group	
132	44	The Trust should ensure that the clock is replaced in the seclusion facility at Mulberry House to enable patients in seclusion to maintain awareness of the time of day.	Replace clock in the seclusion facility at Mulberry House.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Mental Health)	Assistant Director for Adult Mental Health / Care Group Directors for NL	31/03/2016	The clock has been replaced.			Business Division Clinical Governance Group	
133	45	The Trust should review the temperature in the clinic rooms at Swallownest Court to ensure medication is being stored appropriately and safely.	Review the temperature in the clinic rooms at Swallownest Court in line with Safe and Secure Handling of Medicines Policy.	Executive Medical Director	Assistant Director for Adult Mental Health / Care Group Directors for Rotherham	29/02/2016	A system is in place for pharmacy technician staff to review temperature recording at each ward visit and compliance is collated and reported to Medicines Management Committee.		Theme: Medicines Management Links with actions 6, 13, 16 and 17. Trust Pharmacy Strategy	Medicines Management Committee Business Division Medicines Management Group Business Division Clinical Governance Group Team Managers Meetings Adult Mental Health Business Division Risk Register	
134	**Community based mental health services for working age adults**										
135	46	The Trust should ensure that alarms are available in all interview rooms to make sure staff can call for assistance if required.	The Trust will review all community environments where clinical engagement takes place, prioritising by level of risk as identified within the ERICA Group. An action plan to complete this programme of work will be developed / implemented / monitored through the ERICA Group.	Executive Director of Nursing and Quality	Assistant Director for Adult Mental Health / Care Group Directors for Rotherham / Doncaster / NL	31/03/2016	Assistant Director has confirmed that all interview rooms at Ferham Clinic, Rotherham have alarms and the use of these is guided through a Local Working Instruction. Assistant Director and area/building manager completed the required risk assessment on 04/03/2016. Areas of concern identified were escalated through the Trust governance process and action plans developed to mitigate the identified concerns, with the assistance of the Corporate Safety Team.		Links to Actions 3 and 4	Quality and Safety Sub-Committee/Clinical Governance Group Business Division Clinical Governance Group	
136	47	The Trust should ensure teams implement the lone worker policy consistently to support staff safety.	Security team to review lone working arrangements in mental health community services and provide advice and support to staff as required.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Mental Health) / Executive Director of Nursing and Quality	Assistant Director for Adult Mental Health / Care Group Directors for Rotherham / Doncaster / NL	31/03/2016	Team managers issued each staff member in their team with a copy of the Trust Lone Working Policy. Specific team processes in relation to lone working have been discussed at team meetings. Safe working practices have also been reiterated to staff and processes in place to ensure staff safety when undertaking visits outside of normal business hours, with inpatient services providing oversight and a point of contact.	Skyguard alarms are available for use by staff for visits that have been assessed as high risk. These provide a GPS signal for the staff's location.	Links to Action 5.	Quality and Safety Sub-Committee/Clinical Governance Group Business Division Clinical Governance Group	

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5	Ref	CQC Requirements	Action Agreed	Accountable Director	Accountable Assistant Director / Care Group Director	Timescale	Progress Comments	Leading the Way with Care	Golden Thread	Governance	Status
137	48	The Trust should ensure access to psychological therapies and other specialties within the service, is available to all people who require this intervention.	Review current provision of psychological therapies and identify gaps. Identify if this provision is currently commissioned. Raise provision gaps with local commissioners.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Mental Health)	Assistant Director for Adult Mental Health / Care Group Directors for Rotherham / Doncaster / NL	30/09/2016 extend to 30/11/2016 (Phase 1 Transformation Programme)	All psychology posts have now been filled in Rotherham Adult Mental Health services. The psychological therapy review has been completed by Trust lead. Identified gap to be raised with commissioners and reflected through the transformation programme. Lead psychologists have been involved in developing the strategy for psychology provision.		RDaSH TRANSFORMATION PROGRAMME NEWS	Business Division Clinical Governance Group	
138	49	The Trust should continue to increase the provision of Consultant Psychiatrist to the Rotherham Social Inclusion Team.	Complete the medical workforce review, including the provision of consultant psychiatrists across the mental health community services.	Executive Medical Director	Assistant Director for Adult Mental Health / Care Group Directors for Rotherham	31/03/2016 - extend to 30/11/2016 (Phase 1 Transformation Programme)	The medical workforce review is underway and is being included in the transformation programme. Phase 1 of the transformation programme, including Adult and Older People's mental health services will be completed by 30/11/2016 and this will include analysis of the medical workforce requirements and ways of working.		RDaSH TRANSFORMATION PROGRAMME NEWS	Business Division Clinical Governance Group	

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5	Ref	CQC Requirements	Action Agreed	Accountable Director	Accountable Assistant Director / Care Group Director	Timescale	Progress Comments	Leading the Way with Care	Golden Thread	Governance	Status
139	**Long stay / rehabilitation mental health wards for working adults**										
140	50	The Trust should ensure that tools used to calculate minimum staffing levels on wards are robust. Ward staff should be involved in agreeing the levels and ensuring they are maintained. Sufficient staff should be employed as part of the nursing establishment to enable the minimum levels to be achieved and safe staffing information displayed on the Trust website should relate to the agreed minimum levels.	Safe staffing levels for inpatient wards to be reviewed by the Clinical Staffing Review Group. The Clinical Staffing Review Group to continue to monitor Trust dependency levels and take action as required to maintain safe staffing.	Executive Director of Nursing and Quality	Assistant Director for Adult Mental Health / Care Group Directors for Rotherham / Doncaster / NL	31/12/2015	Inpatient staffing levels on the relevant wards have been reviewed by the Clinical Staffing Review Group, which includes representatives from each of the Business Divisions. Staffing levels have been agreed for each of the inpatient wards. Returns against the agreed staffing levels are reported to the Department of Health on a monthly basis and published on the Trust website in line with national guidance. Monthly declarations regarding safe staffing levels are analysed by the Clinical Staffing Review Group. Action is taken as required to maintain safe staffing levels and is reported to the HR&OD Group, and to the People Sub-Committee from April 2016. A review of staffing level guidance for inpatient and community services is being undertaken across the Trust in conjunction with NHS England.		Links to Actions 1, 22, 59 and 70. Nurse Recruitment Strategy	Quality and Safety Sub-Committee Clinical Staffing Review Group	
141	51	The Trust should monitor the on-going use of locum psychiatrists to reduce any negative impact on the consistency of patient care.	Continue to monitor use of locum psychiatrists through HR&OD Group.	Executive Medical Director	Assistant Director for Adult Mental Health / Care Group Directors for Rotherham / Doncaster / NL	31/03/2016	Medical agency and locum cover is reviewed monthly at the People's Sub-Committee and also at the Workforce QIPP Group.		RDaSH TRANSFORMATION PROGRAMME NEWS	People's Sub-Committee Workforce QIPP Group	
142	**Specialist community mental health services for children and young people**										
143	52	The Trust should ensure that staff receive mandatory training in equality and diversity and in conflict resolution in line with its own target.	The Trust has agreed a minimum mandatory / statutory training compliance target of 90% to be achieved by 31 December 2015. Links to Trust wide Mandatory Training Action.	Executive Director of Workforce and Organisational Development	Assistant Director for CAMHS / Children's Care Group Director	31/01/2016	The Learning and Development Team have been visiting each of the Business Divisions to support/check that the trained administrators have any further training needs met and they will also be tasked with checking that information is being input in to the system in a timely and consistent manner. The Learning and Development Team continue to inform Assistant Directors of those staff who are not compliant in each MAST requirement so their attendance can be prioritised. Administrators in each of the Business Divisions have been identified and trained to input mandatory training information/data on to the OLM system. Compliance with mandatory/statutory training has been sustained at 89-90% since February 2016. As at 31/08/2016 compliance in the Child and Adolescent Mental Health Services was 89.42%. Monthly team figures produced for Assistant Director who identifies areas of concerns and highlights to relevant team managers.	Research, Education and Development (RED) Centre have worked additional hours, including evenings and weekends to ensure that sufficient training places are available across the organisation. RED Centre have piloted and implemented the option of a 'patient ready' induction across the Trust for services where it is most beneficial for staff to have completed all requisite training before patient contact. Trust has recently undertaken a Governance Review and has subsequently formed the People's Sub-Committee which is responsible for oversight of training compliance.	Theme: Mandatory and Statutory Training Links with Actions 18, 24, 28, 36, 52, 63, 66, 68 and 75.	People's Sub-Committee/Human Resources and Organisational Development Group Education and Training Forum Business Division Clinical Governance Group	
144	53	The Trust should ensure that staff receive mandatory training Mental Health Act and Mental Capacity Act as part of their induction training.	Implement Mental Health Act / Mental Capacity Act Action Plan, including MCA and DOLS training plan. Monitoring to take place through HR&OD.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Mental Health)	Assistant Director for CAMHS / Children's Care Group Director	30/09/2015	All objectives have been completed and a framework for training developed, which was signed off by the Directors and Assistant Directors. A Training Needs Analysis (TNA) has been undertaken to identify the appropriate staff and training required. This was ratified at the Trust's Joint Management Meeting for discussion and agreement. The mental capacity training commenced in June 2016 and is being delivered by Yvonne Taylor, Mental Capacity Act lead and Richard Tucker, Mental Health Legislation trainer. A learning and development facilitator has also been identified to support with the training. The MCA training framework has been approved by the MHLC sub group, as follows: - MCA Level 1 Training Leaflet has been designed and has been introduced into the Trust induction from 01/04/2016. - MCA Level 2 training is available as an e-learning course and is included on ESR.	Mental Capacity Conference hosted by the Trust in April 2016 titled 'Making Legal Decisions'. Mental Capacity Act Forum established from September 2016.	Theme: Mandatory and Statutory Training Links to Action 20, 26, 28, 37. Links to CQC MHA Action #1, #3, #7 and #9	Mental Health Legislation Committee Business Division Clinical Governance Group	
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5	Ref	CQC Requirements	Action Agreed	Accountable Director	Accountable Assistant Director / Care Group Director	Timescale	Progress Comments	Leading the Way with Care	Golden Thread	Governance	Status
146							- Half day training courses for managers have been scheduled throughout 2016/17 and are included in the Learning and Development Programme for 2016/17 The programmes are available within the Corporate Learning and Development Programme for staff to access and book onto available sessions. It is also advertised through the daily communications bulletin and information sent direct to senior managers. Now that the TNA and training programme has been agreed and the Trust is in the process of attaching competencies to individual staff training matrix on the Electronic Staff Record (ESR) system.				
147	54	The Trust should ensure that non-medical staff receive managerial appraisal of their work performance.	All staff to continue to have Personal Development Review (PDR) and 1:1 in line with Trust policy and be recorded on the electronic staff record.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children & Communities)	Assistant Director for CAMHS / Children's Care Group Director	31/03/2016	All locally held PDR information has been inputted into ESR and systems have been implemented to ensure that all future PDRs are inputted. The compliance percentage as at 31/07/2016 was 64.5% across the CAMHS Business Division, which has increased from 43.4% in September 2015. The service continues to increase uptake of Person Development Reviews and this is monitored by the Assistant Director and People's Sub-Committee.		Links to Action 68	Quality Committee People's Sub-Committee/Human Resources and Organisational Development Group Education and Training Forum Business Division Clinical Governance Group	
148	55	The Trust should ensure that communication with people who use the service who are waiting for assessment after referral is improved, ensuring patients have a point of contact.	Single point of access duty team to send letters to patients following referral to update patients on expectations.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children & Communities)	Assistant Director for CAMHS / Children's Care Group Director	29/02/2016	The duty team in all areas is included with the single point of access. This is promoted with commissioners and on the Trust website. Letters are sent to service users on receipt of referrals which includes contact details for the service, using templates designed by young people. Service users can contact the Children and Families Team by telephone during the period from referral to assessment, ensuring that support is in place. Waiting times and contact with the service is reducing as a theme in complaints received by the service.	Service is undertaking programme of work to reduce working times and agency usage which will ultimately reduce the need to remain in contact with people while waiting for an assessment		Finance, Information and Performance Committee Rotherham CAMHS Performance Meetings Business Division Clinical Governance Group Fortnightly meetings with Rotherham CCG	
149	**Wards for older people with mental health problems**										
150	56	The Trust should ensure that all members of the multidisciplinary team work in an integrated and effective way.	To identify clear procedural requirements with regard to multi-disciplinary engagement throughout inpatient stay.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Mental Health)	Assistant Director for Older People's Mental Health / Care Group Directors for Rotherham / Doncaster / NL	29/02/2016	The Older People's Mental Health Services Modern Matrons have established and held meetings of the working group to define the operational standards and expectations of multi-disciplinary working within an inpatient environment. A Standard Operating Procedure was subsequently produced and presented Assistant Director for approval. This provides clear definition of the function, role and responsibility within the multi-disciplinary working environment and an accompanying flowchart has also been produced to support interpretation of this SOP it is available in all ward areas.			Business Division Clinical Governance Group	
151	57	The provider should ensure patients are cared for in the least restrictive way.	Staff training and development to include MCA training and compliance to least restrictive interventions.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Mental Health)	Assistant Director for Older People's Mental Health / Care Group Directors for Rotherham / Doncaster / NL	31/03/2016	All patients have individual care plans in place that are developed to reflect their individual needs. Where there are any restrictions in place for an individual, these are routinely reviewed to ensure that they remain appropriate. The service is participating in a volume of work relating to consent and mental capacity which is reference in the update for Action 20.		Links to CQC MHA Action #13	Reducing Restrictive Interventions Group Business Division Clinical Governance Group	
152	**Community based mental health services for older people**										
153	58	The Trust must ensure that all care plans across the community mental health teams are personalised and recovery-focused.	Review existing care plans.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Mental Health)	Assistant Director for Older People's Mental Health / Care Group Directors for Rotherham / Doncaster / NL	31/03/2016	The team has identified patients who do not have a personalised and recovery-focused care plan, and completed reviews.		Theme: Record Keeping Links to Actions 8, 12, 21 and 33. Recovery Strategy Care Records Audit	Business Division Clinical Governance Group	
154			The Community Managers Group to develop and implement service specific care planning and risk assessment templates, both in electronic patient record and paper format, for each of the Trust	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Mental Health)	Assistant Director for Older People's Mental Health / Care Group Directors for Rotherham / Doncaster / NL	08/02/2016	Membership and format of the Community Managers Group has been agreed, a key initial priority for this group is comprehensive review of care planning and risk assessment records across the organisation.				

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155			community services.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Mental Health)	Assistant Director for Older People's Mental Health / Care Group Directors for Rotherham / Doncaster / NL	29/02/2016	The first meeting of the Community Managers Group took place on 14/03/2016, chaired by the Service Director (Mental Health). The terms of reference were ratified at the meeting.				
156				Chief Operating Officer (w/e/f 01/07/2016) Service Director (Mental Health)	Assistant Director for Older People's Mental Health / Care Group Directors for Rotherham / Doncaster / NL	31/03/2016	Each team has identified their present position and continue to review all risk assessments. This includes establishing the risk assessment and care planning requirements for each community service in both electronic and paper format.				
157				Chief Operating Officer (w/e/f 01/07/2016) Service Director (Mental Health)	Assistant Director for Older People's Mental Health / Care Group Directors for Rotherham / Doncaster / NL	30/06/2016 extended to 30/11/2016 following Big Conversation meetings and identified need for broader pilot phase	Work to implement to embed agreed risk assessment and care planning templates with appropriate monitoring arrangements in place as agreed by the Community Managers Group is on-going. Meetings have taken place (Big Conversation and Themes and Trends Analysis) where it has been agreed that there are challenges with the existing risk assessment tool. This programme of work is now being progressed through a specific Listening into Action project, which has identified seven actions under the following headings: - Patient Complexity Risk Screening Tool to be reviewed and adjusted to ensure it is suitable for all services - Risk Management - Policy Review - Audit - Use of the term 'Recovery' - Central coordination - Electronic system review and planning These are currently in progress. Due to the level of engagement from clinicians across the Trust, the engagement phase has been extended with pilots scheduled to commence 1st November 2016. Following this pilot the tools will be reviewed and audited for efficacy, with a nurse and medical lead already identified to undertake this.				
158	59	The Trust must ensure that staffing levels and caseloads for community mental health teams follow Department of Health guidance.	Identify relevant DoH guidance on staffing and caseloads for community mental health teams.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Mental Health)	Assistant Director for Older People's Mental Health / Care Group Directors for Rotherham / Doncaster / NL	31/03/2016	Individual staff have regular bi-monthly clinical and managerial supervision to review caseload including complexity of caseload, priorities and capacity. Staffing and caseload levels continues to be discussed through the Clinical Staffing Review Group.		Links to Actions 1, 22, 50 and 70.	Clinical Staffing Review Group Business Divisional Clinical Governance Group	
159	**Community health services for adults**										
160	60	The Trust should review risk assessments and reviews to ensure they are completed accurately.	Review ALL risk assessment documentation in use within DCIS Adults to ensure it is fit for purpose, supported by policy and meets patient need.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for DCIS / Doncaster Care Group Director	31/03/2016	Staff workshop took place on 01/03/2016 to scope work. Work has subsequently taken place within community healthcare services to review all current risk assessment documentation and policies to ensure that there are consistent standards and expectations across services together with clear guidance for staff.	To further support this work, Internal Audit have undertaken an audit of current use and compliance with risk assessments across in-patients and community services. The report from this has now been received and the outcome will be combined with the risk assessment review currently being undertaken as part of Listening into Action and will form a focus of the next phase of the Trust's Quality Improvement Strategy.	Theme: Risk Assessment and Record Keeping Links to Actions 2, 7, 12, 19 and 65. Care Records Audit Listening into Action		
161			Community Managers Group to review the TPP templates for the risk assessments to make sure they are easy to use, streamlined and fit for purpose.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for DCIS / Doncaster Care Group Director	31/03/2016	Templates for risk assessments on TPP SystmOne have been reviewed with the TPP system team and Clinical Practice Educators. The revised templates now being used have been simplified and streamlined to enable clinicians to access and complete risk assessments and be alerted to assessments that still need to be completed.				
162			All services to review Record Audit results and develop action plan.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for DCIS / Doncaster Care Group Director	30/04/2016	Recommendations from Internal Audit have been received and have been shared at the Clinical Governance and Assurance Meeting with the Area Clinical Managers and Clinical Director. The findings and recommendations have been addressed via team actions and also fed into the Trust wide work on LiA workstream on risk assessments. Pilot of the revised tools commenced in June 2016 and these have now been implemented across services.				
163			Spot checks by service leads re Risk Assessments to ensure completed appropriately.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for DCIS / Doncaster Care Group Director	29/02/2016	Random spot-checks have been undertaken and informed a dialogue with Internal Audit undertaking a wider audit of risk assessments across a sample of patient records during March and April 2016.				

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5	Ref	CQC Requirements	Action Agreed	Accountable Director	Accountable Assistant Director / Care Group Director	Timescale	Progress Comments	Leading the Way with Care	Golden Thread	Governance	Status
164			Community Practice Educator to provide update training re: Risk Assessments for all staff.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for DCIS / Doncaster Care Group Director	31/03/2016	Templates for risk assessments on TPP SystmOne have been reviewed with the TPP system team and Clinical Practice Educators. Training on the simplified and streamlined templates has been completed.				
165			Review, contribute and implement any changes of risk assessment as a result of any Trust wide actions undertaken.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for DCIS / Doncaster Care Group Director	31/07/2016 extended to 30/09//2016 following Big Conversation meetings	Work to implement to embed agreed risk assessment and care planning templates with appropriate monitoring arrangements in place as agreed by the Community Managers Group is on-going. Meetings have taken place (Big Conversation and Themes and Trends Analysis) where it has been agreed that there are challenges with the existing risk assessment tool. This programme of work is now being progressed through a specific Listening into Action project, which has identified seven actions under the following headings: - Patient Complexity Risk Screening Tool to be reviewed and adjusted to ensure it is suitable for all services - Risk Management - Policy Review - Audit - Use of the term 'Recovery' - Central coordination - Electronic system review and planning These are currently in progress. Due to the level of engagement from clinicians across the Trust, the engagement phase has been extended with pilots scheduled to commence 1st November 2016. Following this pilot the tools will be reviewed and audited for efficacy, with a nurse and medical lead already identified to undertake this. DCIS is taking part in this Trust wide LiA workstream on risk assessment which has included engagement on revised ways of working in relation to risk assessments. The outcome of this work will form a focus of the next phase of the Trust's Quality Improvement Strategy.			
166	61	The Trust should review clinical supervision arrangements for all community staff.	Undertake an audit of clinical supervision records to establish where clinical supervision is not taking place and where it is, if it is being recorded correctly.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for DCIS / Doncaster Care Group Director	29/02/2016	Random audits have taken place and identified a mix of some supervision taking place but not being recorded and some instances where clinical supervision is not taking place. A robust system for the monitoring of uptake of clinical supervision have now been implemented, overseen by the Community Hubs for each area and reports regularly sent to managers for follow-up.	Service has undertaken a 'SurveyMonkey' to understand staff perception of clinical supervision and identify improvements that will benefit staff.	Nurse Revalidation	Business Division Clinical Governance Group	
167			Develop appropriate systems and processes in response to the audit findings to book clinical supervision and record accurately when it has taken place.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for DCIS / Doncaster Care Group Director	31/03/2016	A process review has taken place and a new system for recording clinical supervision has been developed and is being implemented in April 2016. Clinical Supervision is monitored at the monthly business division clinical governance and assurance meeting.				
168			Promote the value and requirement for clinical supervision with staff and link to revalidation.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for DCIS / Doncaster Care Group Director	29/02/2016	Quality Workshop held with a cross section of staff on 01/03/2016 where risk assessments and clinical supervision were discussed. Key actions for improvement were discussed and noted and will be implemented during March 2016.				
169			Undertake spot check audits on a monthly basis.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for DCIS / Doncaster Care Group Director	31/03/2016	Work undertaken in DCIS during April - June 2016 resulted in a significant increase in the number of staff having a clinical supervision contract in place and undertaking clinical supervision. Each service hub is reporting against this on a monthly basis and administrative systems for recording have been implemented and improved.				
170	62	The Trust should develop arrangements to support patients with dementia.	Check compliance of all staff with dementia training to maintain at 90%.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for DCIS / Doncaster Care Group Director	31/01/2016	Dementia training data was extracted and was reviewed at management team meeting with necessary actions taken by end of January 2016.		`	Doncaster Clinical Commissioning Group CQUIN Meetings Business Division Clinical Governance Group	

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5	Ref	CQC Requirements	Action Agreed	Accountable Director	Accountable Assistant Director / Care Group Director	Timescale	Progress Comments	Leading the Way with Care	Golden Thread	Governance	Status
171			Audit the use of the Find, assess, refer tool, for identifying patients who have symptoms of dementia.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for DCIS / Doncaster Care Group Director	30/09/2016	Data on the use of the Find, Assess, Refer tool is reported quarterly for inpatient areas as part of the National CQUIN. This evidences that an average of 100% inpatients and 50% of community patients have a dementia screening questionnaire completed.				
172			Undertake work with Older People's Mental Health as part of the Parity of Esteem CQUIN to develop common pathways or joint care.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for DCIS / Doncaster Care Group Director	30/09/2016	Scoping CQUIN and milestones for 2016/17 has been completed as part of contract negotiation process. Implementation plans have identified patients that are separately accessing mental health and physical health services of the Trust. The Trust will reviewed pathways in quarter 1 and 2, 2016/17 and the outcome of this has formed a focus of the foundation for the Trust's Transformation Programme and Care Group Model.				

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5	Ref	CQC Requirements	Action Agreed	Accountable Director	Accountable Assistant Director / Care Group Director	Timescale	Progress Comments	Leading the Way with Care	Golden Thread	Governance	Status
173	**Community health inpatients**										
174	63	The Trust should develop a consistent and accurate record of mandatory training.	All managers to review compliance and recording of compliance with every team, and book staff on any areas of outstanding training.	Executive Director of Workforce and Organisational Development	Assistant Director for DCIS / Doncaster Care Group Director	31/03/2016	The Learning and Development Team have been visiting each of the Business Divisions to support/check that the trained administrators have any further training needs met and they will also be tasked with checking that information is being input in to the system in a timely and consistent manner. The Learning and Development Team continue to inform Assistant Directors of those staff who are not compliant in each MAST requirement so their attendance can be prioritised. Administrators in each of the Business Divisions have been identified and trained to input mandatory training information/data on to the OLM system. Compliance with mandatory/statutory training has been sustained at 89-90% since February 2016. As at 31/09/2016 compliance in the Doncaster Community Integrated Services 89.11%. Monthly team figures produced for Assistant Director who identifies areas of concerns and highlights to relevant team managers.	Research, Education and Development (RED) Centre have worked additional hours, including evenings and weekends to ensure that sufficient training places are available across the organisation. RED Centre have piloted and implemented the option of a 'patient ready' induction across the Trust for services where it is most beneficial for staff to have completed all requisite training before patient contact. Trust has recently undertaken a Governance Review and has subsequently formed the People's Sub-Committee which is responsible for oversight of training compliance.	Theme: Mandatory and Statutory Training Links with Actions 10, 18, 24, 28, 36, 52, 66, 68 and 75.	People's Sub-Committee/Human Resources and Organisational Development Group Education and Training Forum Business Division Clinical Governance Group	
175	64	The Trust should ensure its vision and strategy are clearly documented and linked to its strategic objectives.	Review vision and strategy in conjunction with Doncaster Clinical Commissioning Group as part of the current review of Intermediate Care across Doncaster.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for DCIS / Doncaster Care Group Director	31/06/2016	Posters containing Trust's vision, mission, values and strategic objectives circulated to all areas to reemphasise these across the organisation. Staff knowledge of these has also been tested through team meetings and informal quizzes. The local service offer and vision is contained with the operational policies for the services. DCIS Inpatient Wards have been working jointly with patients, carers and commissioners to redesign services as part of a broad Intermediate Care Review. Staff have been engaged in this process throughout and informed of outcomes at each stage of development.	The service is engaging in national reviews of Neurological Rehabilitation Service provision. Service has hosted a number of Leadership Forums for managers and clinical leaders across the service incorporating a strategic update on local and national priorities and the Healthcare Leadership Model.		Business Division Clinical Governance Group	
176	65	The Trust should review the process of recording risk.	360 Assurance to undertake audit of risk assessment and care planning in DCIS services. Action plan to be developed in response to recommendations. DCIS will adapt its approach to recording risks as agreed by the organisation wide Risk Strategy following consideration of this recommendation.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for DCIS / Doncaster Care Group Director	30/04/2016 extended to 30/11/2016 following Big Conversation meetings and identified need for broader pilot phase	Random spot-checks were undertaken that identified areas for discussion with Internal Audit. Internal Audit has now completed a wider audit of risk assessments across a sample of patient records and the report has recently been received by the Trust. The outcome of this will be combined with the risk assessment review currently being undertaken as part of Listening into Action and will form a focus of the next phase of the Trust's Quality Improvement Strategy. To progress the Listening into Action review of risk assessments, meetings have ken place (Big Conversation and Themes and Trends Analysis) where it has been agreed that there are challenges with the existing risk assessment tool. This programme of work is now being progressed through a specific Listening into Action project, which has identified seven actions under the following headings: - Patient Complexity Risk Screening Tool to be reviewed and adjusted to ensure it is suitable for all services - Risk Management - Policy Review - Audit - Use of the term 'Recovery' - Central coordination - Electronic system review and planning These are currently in progress. Due to the level of engagement from clinicians across the Trust, the engagement phase has been extended with pilots scheduled to commence 1st November 2016. Following this pilot the tools will be reviewed and audited for efficacy, with a nurse and medical lead already identified to undertake this.	Trust undertaking pilot of complexity tool to ensure targeted assessment and management of risk through Trust's Listening into Action movement Listening into Action	Theme: Risk Assessment and Record Keeping Links to Actions 2, 7, 12, 19 and 60. Care Records Audit.	Quality and Safety Sub-Committee/Clinical Governance Group Business Division Clinical Governance Group	

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5	Ref	CQC Requirements	Action Agreed	Accountable Director	Accountable Assistant Director / Care Group Director	Timescale	Progress Comments	Leading the Way with Care	Golden Thread	Governance	Status
177	**Community End of Life Care**										
178	66	The Trust should ensure staff receive mandatory training and that it is recorded.	All managers to review compliance and recording of compliance with every team and book staff on any areas of outstanding training.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for DCIS / Doncaster Care Group Director	31/01/2016	The Learning and Development Team have been visiting each of the Business Divisions to support/check that the trained administrators have any further training needs met and they will also be tasked with checking that information is being input in to the system in a timely and consistent manner. The Learning and Development Team continue to inform Assistant Directors of those staff who are not compliant in each MAST requirement so their attendance can be prioritised. Administrators in each of the Business Divisions have been identified and trained to input mandatory training information/data on to the OLM system. Compliance with mandatory/statutory training has been sustained at 89-90% since February 2016. As at 31/08/2016 compliance in the Doncaster Community Integrated Services 89.11%. Monthly team figures produced for Assistant Director who identifies areas of concerns and highlights to relevant team managers.	Research, Education and Development (RED) Centre have worked additional hours, including evenings and weekends to ensure that sufficient training places are available across the organisation. RED Centre have piloted and implemented the option of a 'patient ready' induction across the Trust for services where it is most beneficial for staff to have completed all requisite training before patient contact. Trust has recently undertaken a Governance Review and has subsequently formed the People's Sub-Committee which is responsible for oversight of training compliance.	Theme: Mandatory and Statutory Training Links with Actions 10, 18, 24, 28, 36, 52, 63, 68 and 75.	People's Sub-Committee/Human Resources and Organisational Development Group Education and Training Forum Business Division Clinical Governance Group	
179	67	The Trust should review the use of inpatient hospice beds to enable the needs of the population to be safely met in a timely manner.	Hospice specification to be reviewed and agreed with Doncaster Clinical Commissioning Group, including the use of hospice beds and also focusing on specialist palliative care in the community to enable patient choice.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for DCIS / Doncaster Care Group Director	30/06/2016	The Macmillan Nurses and Hospice at Home they have been integrated into one team to provide Specialist Palliative Care services in the community across the whole of Doncaster . This service is now able to provide a 7 day a week service as opposed to a 5 day, both visiting community patients and triaging patient referrals to the whole pathway. The service is now caring for patients on the in-patient unit who require end of life care and the Hospice is their preferred place of care and those patients who require complex symptom management. Figures from the previous 3 months who were admitted to the hospice in-patient unit for either specialist palliative care or End of life are as follows: - Specialist Palliative Care 67% - EOLC 33% The service held a drop in event on 20 September 2016 for professionals across Doncaster to share messages about the revised model and the service available. While bed occupancy has remained low (circa 65%) the service has done a lot of work to raise awareness of its availability but also to support people with the end of their life at home where this is their preference.	In response to patient, carer and commissioner requirements a single point of entry and triage system has been implemented for the services currently provided by the Hospice, the Specialist Palliative Care team (Macmillan) and the Hospice at Home team. These service access points have been combined into a single system with one number for contact which will be available 7 days a week. The clinical triage clinician can then assess the individual's needs and make a decision as to the most appropriate level of care to be provided at that point in time which would cover care options across the whole pathway both in a patient's own home and in an inpatient Hospice bed.		Quality and Safety Sub-Committee/Clinical Governance Group Business Division Clinical Governance Group	

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5	Ref	CQC Requirements	Action Agreed	Accountable Director	Accountable Assistant Director / Care Group Director	Timescale	Progress Comments	Leading the Way with Care	Golden Thread	Governance	Status
180	**Community health services for children, young people and families**										
181	68	The Trust should ensure that local training and appraisal records are reviewed to help make trust-wide training and appraisal data accurate.	All managers to review compliance and recording of compliance with every team and book staff on any areas of outstanding training.	Executive Director of Workforce and Organisational Development	Assistant Director for DCIS - Children and Families / Children's Care Group Director	31/03/2016	The Learning and Development Team have been visiting each of the Business Divisions to support/check that the trained administrators have any further training needs met and they will also be tasked with checking that information is being input in to the system in a timely and consistent manner. The Learning and Development Team continue to inform Assistant Directors of those staff who are not compliant in each MAST requirement so their attendance can be prioritised. Administrators in each of the Business Divisions have been identified and trained to input mandatory training information/data on to the OLM system. Compliance with mandatory/statutory training has been sustained at 89-90% since February 2016. As at 31/08/2016 compliance in the Children, Young People and Families Service was 87.95%, however, it has been agreed that Clinical Risk Assessment Training should be removed from all staff matrices which is underway. Once complete true compliance would be 91%. Monthly team figures produced for Assistant Director who identifies areas of concerns and highlights to relevant team managers.	Research, Education and Development (RED) Centre have worked additional hours, including evenings and weekends to ensure that sufficient training places are available across the organisation. RED Centre have piloted and implemented the option of a 'patient ready' induction across the Trust for services where it is most beneficial for staff to have completed all requisite training before patient contact. Trust has recently undertaken a Governance Review and has subsequently formed the People's Sub-Committee which is responsible for oversight of training compliance.	Theme: Mandatory and Statutory Training Links with Actions 10, 18, 24, 28, 36, 52, 63, 66 and 75.	People's Sub-Committee/Human Resources and Organisational Development Group Education and Training Forum Business Division Clinical Governance Group	
182	69	The Trust should engage with the local acute Trust to ensure that data being used to plan health visits to new mothers is accurate and communicated in a timely manner.	Continue to meet with the acute Trust to discuss and resolve data transfer issues.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for DCIS - Children and Families / Children's Care Group Director	30/06/2016 Extended to 30/11/2016 due to work required to be undertaken by DBHFT	The issue with the local acute Trust has been identified on the DCIS risk register. IR1s are completed for all issues identified. Monthly meetings with DBHFT continue to discuss any issues highlighted to ensure the accuracy of the communication and this was raised again at a Provider to Provider Service Review Meeting on 19 September 2016 with the DBHFT Head of Performance agreeing to take this away as an action. Interim plans are in place to address issues, which continue to be raised at the regular provider to provider meetings. Work continues to address this concern and work towards resolution. The receipt of notifications form Doncaster and Bassetlaw Hospital (DBH) and routine flow has delivered improvements, however information is still sent manually. This has been highlighted to the RDaSH Chief Executive via a briefing paper who continues to escalate the issue.			RDaSH/DBHFT Provider to Provider Meetings Business Division Clinical Governance Group	
183	70	The Trust should review how it manages and measures caseloads for health visitors and school nurses.	Changes to caseloads to be agreed following the implementation of the redesigned 4,5,6 model. School nurses use a risk stratification tool to identify cases and allocate based on level of need.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for DCIS - Children and Families / Children's Care Group Director	31/03/2016	National Guidance in Call to Action says 250 cases per health visitor. The remodelling to the 4,5,6 model from September 2015 means the service has reviewed all caseload numbers. Currently there are vacancies that are being recruited into to maintain appropriate staffing levels. There are currently 9 vacancies within the health visiting workforce which are been held for staff at risk and student health visitors who qualify shortly. The review of the model within mainstream school nursing in Doncaster is completed and commenced in practice from August 2016. This has separate teams to deliver the public health aspect and an immunisation team.	A complete review of the ways of working in the School Nursing Service has recently been undertaken.	Links to Actions 1, 22, 50 and 59.	Business Division Clinical Governance Group	
184	71	The Trust should continue to take action to meet its target in regard to breastfeeding.	Service taking part in the Nourishing Start to Health research. Peer mentors programme continues, Continuing with the actions as part of building community capacity. Breast start groups review in January 2016. Supporting Children Centres to gain Level 1 BFI.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for DCIS - Children and Families / Children's Care Group Director	31/03/2016	RDaSH sustained its Level 3 rating for UNICEF Baby Friendly Initiative in May 2016. There is a continued recruitment process established for cohorts of peer mentors. The health visiting service continues to offer feeding support in the first week following a new birth; offering telephone support, home visits and breast pump loan where appropriate. In January 2016 the 2 day training for children centre staff was delivered by the RDaSH Infant Feeding co-ordinator (0-5 pathway) as a part of supporting the children centres in their pursuit of Unicef BFI Level 1. Nursery Nurses support the peer support training within the children centres.	Service calls all new mothers within 48 hours of birth for wellbeing check and discussion about breastfeeding. The Trust has engaged in Nourishing Start to Health (NOSH) research study and the work for this has now been completed and we await the results of the research study which are being undertaken by Sheffield University.		Business Division Clinical Governance Group UNICEF BFI Accreditation	

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5	Ref	CQC Requirements	Action Agreed	Accountable Director	Accountable Assistant Director / Care Group Director	Timescale	Progress Comments	Leading the Way with Care	Golden Thread	Governance	Status
185	**Forensic Inpatient / Secure Wards**										
186	72	The Trust should consider redeveloping the seclusion facilities within the service in line with current statutory standards to ensure that patients are always treated with respect and dignity as required by the Mental Health Act Code of Practice. The Trust should ensure that design factors (paragraph 26.109 of the MHA Code of Practice) have been taken into account 'there should be not apparent safety hazards' and 'rooms should not have blind spots and alternate viewing panels should be available where required.'	Review seclusion room plans in line with current statutory standards and submit for costing.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for LD and Forensics / Doncaster Care Group Director	30/06/2016	Review undertaken by service and estates staff and areas requiring improvement submitted for costing to third party provider. Prices now received from company. As a result of the actions suggested, the Trust has launched a Trust-wide review of seclusion facilities to ensure consistency across all Trust services. Therefore to ensure access to seclusion facilities during any refurbishment works, this action will now be completed as part of the Trust-wide Seclusion Review Programme. Following the review a decision will be made about whether to progress with the suggested works at this stage or incorporate into wider Amber Lodge Redevelopment Programme when underway. Amber Lodge Building Review Group continues to meet regularly and a commissioned expert advisor to sit on membership of meeting.	Visual, easy-read updates on the plans for the seclusion facility and broader works on Amber Lodge presented on the ward area.	Links to Actions 34, 42, 43 and 44. Links to CQC MHA Action #12 Amber Lodge Building Redevelopment Programme	Quality and Safety Sub-Committee/Clinical Governance Group Reducing Restrictive Interventions Group Amber Lodge Building Review Group	
187			Engage in Trust-wide review of Seclusion Suite Specification	Chief Operating Officer	Assistant Director for LD and Forensics / Doncaster Care Group Director	31/12/2016	The business division is represented on the Trust-wide review of Seclusion Services. It has therefore been agreed with the Director of Nursing and Quality that the decision regarding the extent of the works to the Amber Lodge Seclusion Facility will be taken once this review has been completed in order to ensure consistency. Therefore, in order for there to be minimal disruption to patients as a result of the requirement for the seclusion facility to be closed while any refurbishment work is underway, all work will be undertaken at once later in the year which will incorporate the recommendations made by the CQC, the outcome of the Trust review and the outcome of a recent review undertaken by an expert Security Reviewer. A programme of works has now been developed and a draft Seclusion Suite developed which is out for consultation with key clinicians and stakeholders across the organisation. During the interim period, the potential impact on patients of work not being undertaken immediately is being mitigated by individual risk assessments being undertaken for each patient and a bespoke Seclusion Care Plan developed following this to ensure that the least restrictive approach is taken for each individual. The service is also in the process of reviewing whether any works could be undertaken that would improve the area without the need to close the seclusion facility for refurbishment and an update on this will provided as soon the review has been completed.				
188			Finalise seclusion room plans and instruct company to undertake refurbishment work	Chief Operating Officer	Assistant Director for LD and Forensics / Doncaster Care Group Director	31/12/2016	Outcome of the above Trust-wide review awaited before progressing.				
189	73	The Trust should avoid blanket restrictions, such as smoking and bed times, in accordance with paragraph 8.7 of the Code of Practice.	Ensure that patients can have a cigarette when they wish and are able to decide when to retire to bed. Ensure there are plans in place to support the no smoking implementation on 01/03/2016.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for LD and Forensics / Doncaster Care Group Director	31/03/2016	A full programme of activities was arranged for the 2 weeks following the Trust formally becoming smoke free on 01/03/2016. All patients on Amber Lodge have now been successfully supported to stop smoking in line with the Trust's smoke free strategy. Patients have attended the regional CQUIN forums to discuss how they have stopped smoking and presented at the official Trust launch supported by ward staff. Healthy eating options have also been discussed with patients as weight gain can become an issue when some people stop smoking. Bedtimes continue to be reviewed in partnership with patients on an on-going basis via the weekly community meeting and agreed bedtimes now set according to patient's own discretion.	Service offered awards to patients at their smoke free milestones and the Assistant Director and Business Development Manager attended the ward to present these.	SMOKEFREE Recovery College CQUIN	Smoke-Free Implementation Group	
190	74	The Trust should ensure that the checking of patients' mobile phone message logs and calls is based on individual risk assessments in line with the Code of Practice guidance.	Allow patients to keep their mobile phones at all times, without staff checking the contents, unless there is an identifiable risk.	Chief Operating Officer (w/e/f 01/07/2016) Service Director (Children's and Communities)	Assistant Director for LD and Forensics / Doncaster Care Group Director	30/11/2015	Patients' mobile phones have been given to all patients without any restrictions unless it is explicitly care planned on an individual basis and there is a clear rationale for this that has been discussed and agreed in Clinical Multi-Disciplinary Team meeting and with the patient. Any restrictions in place are reviewed at each MDT Meeting to ensure that these remain appropriate and are removed if there is any change in circumstances. SOP relating to use of mobile phone by patients updated to ensure no inferred blanket restrictions. Individual care planned approach continues to be taken for each individual to ensure that there are no blanket restrictions in place. The decision regarding mobile phone access for each patient is reviewed regularly at the Multi-Disciplinary Team meeting to ensure that it remains appropriate.			Business Division Clinical Governance Group	

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5	Ref	CQC Requirements	Action Agreed	Accountable Director	Accountable Assistant Director / Care Group Director	Timescale	Progress Comments	Leading the Way with Care	Golden Thread	Governance	Status
191	75	The Trust should ensure that all staff attend mandatory training.	The Trust has agreed a minimum mandatory / statutory training compliance target of 90% to be achieved by 31 December 2015.	Executive Director of Workforce and Organisational Development	Assistant Director for LD and Forensics / Doncaster Care Group Director	31/03/2016	Compliance in the Forensic Business Division as at 31 July 2016 was 86.74%. All outstanding training has been booked and completion monitored and actioned via the HR Division meeting.	Research, Education and Development (RED) Centre have worked additional hours, including evenings and weekends to ensure that sufficient training places are available across the organisation. RED Centre have piloted and implemented the option of a 'patient ready' induction across the Trust for services where it is most beneficial for staff to have completed all requisite training before patient contact. Trust has recently undertaken a Governance Review and has subsequently formed the People's Sub-Committee which is responsible for oversight of training compliance.	Theme: Mandatory and Statutory Training Links with Actions 10, 18, 24, 28, 36, 52, 63, 66 and 68.	People's Sub-Committee/Human Resources and Organisational Development Group Education and Training Forum Business Division Human Resources Group	
192	76	The Trust should ensure that oxygen in the emergency resuscitation bags is regularly checked and is in date.	Complete audit to check dates on all oxygen cylinders on inpatient wards.	Executive Director of Workforce and Organisational Development	Assistant Director for LD and Forensics / Doncaster Care Group Director	30/09/2015	All areas contacted and cylinders audited to check dates on all oxygen cylinders on a daily basis. Included as part of 12 weekly audits carried out by Resuscitation Service and monitored by the Trust Resuscitation Committee. The Forensic Business Division was fully compliant with the Emergency Equipment Audit for Quarter 4, 2015/16 with no follow up actions recommended. The Forensic Business Division remained fully compliant with the Emergency Equipment Audit for Quarter 1, 2016/17, again with no follow up actions recommended.	All emergency equipment bags in use across the organisation now replaced.	Links to Actions 15 and 41.	Resuscitation Committee Clinical Quality Group Quality and Safety Sub-Committee	