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1.a	Must	Wards for older people with mental health problems	The Trust must ensure patients have access to psychological therapies	To review the provision of psychological therapies across the Trust. To consider and describe the model of psychological therapies for patients. To implement a strategy which enables access to psychological therapies for all patients who require it.	Jun-19		Quality Improvement (QI) project in place which has reviewed current status and proposed improvements based on NICE guidance to accessing psychological therapies including 3 new posts to work across inpatients/community services and staff training to provide psychological informed practice to patients. Training programme 'Comprehend, cope and connect' as used in italk and AMH.	**On track**	Patients have access to psychological therapies across the Trust based on the National Institute for Health and Care Excellence (NICE) guidance. There will be agreed clinical models within services based on NICE guidance.	Re - review provision of psychological therapies across the Trust. Clinical models within services are embedded.	Sep-19		I x new post started in North area and 2 posts currently being recruited - Fareham & Gosport 3 days CMHT and 2 days inpatient; Eastleigh/New Forest East/Romsey 3 days CMHT and 2 days inpatient Melbury Lodge.	**On track**
1.b	Should	Community-based mental health services for older people	The Trust should review the provision of psychologist input to the service to ensure this is equitable across the service	**see action 1.a**				**Duplicate**						**Duplicate**
1.c	Should	Long stay/rehabilitation mental health wards for working age adults	The Trust should review the input of psychologists on both wards	**see action 1.a**				**Duplicate**						**Duplicate**
1.d	Should	Mental health crisis services and health based places of safety	Ensure patients have consistent access to psychiatry and psychology support and treatment	**see action 1.a** To review the provision of psychiatry across the crisis teams. To consider and describe the model of psychiatry for patients. To implement a strategy which enables access to psychiatry across the crisis teams.	Jun-19		Quality Improvement project reviewing crisis support and care pathways. Currently crisis support provided for OPMH patients on case by case consultation basis with consultants in adult mental health. Revised divisional structures in trust will support ageless service.	**On track**	Patients have access to psychiatry based on their needs and best practice recommendations. There will be agreed clinical models within services based on best practice recommendations.	Re-review the provision of psychiatry across the crisis teams. Clinical models within services are embedded.	Sep-19		Will re-review psychiatry provision as follow on from QI project.	**On track**
1.e	Must	Acute wards for adults of working age and psychiatric intensive care units (PICU)	The Trust must ensure that the safer staffing levels are met on all the wards to ensure safe care and treatment of patients. This includes consistent medical cover across the wards.	To deliver Year one of the Five Year People and Organisational Development Strategy (2018 - 2022). To strengthen the operational use of the Safer Staffing policy and procedures.	Sep-19		Ongoing initiatives to recruit and retain staff - open days, use of social media, international recruitment, personal development courses. New safer staffing lead appointed. Workforce plans in services/teams/wards. Ongoing staffing pressures.	**On track**	No clinical teams with a vacancy rate of over 10% at any one time. Agency and locum spend less than 1%. Competency based workforce plans in place for every service - based on demand, capacity, competency and income.	Implementation of People and Organisational Development Strategy. Implementation of Safer Staffing key performance indicators (KPI).	Dec-19		Workforce Development Committee has oversight of ongoing workforce status and initiatives to recruit and retain staff.	**On track**
1.f	Must	Wards for older people with mental health problems	The Trust must ensure that staffing is at a safe level on Beaulieu ward at all times	**see action 1.e** To deliver the workforce plan for Older Peoples Mental Health services.	Dec-18	Jun-19	Beaulieu ward admissions suspended in November due to staffing issues. Reopened 3 June with new leadership on ward and safer staffing levels in place. Will open in phased way with small number patients in first week and then increasing. Ongoing workforce plan in place.	**Completed**	Services are staffed at levels which enable safe care and treatment of patients as per our policy standard.	Implementation of People and Organisational Development Strategy. Safer Staffing reports.	Dec-19	Dec-19	Ongoing monitoring of staffing levels via safer staffing reports/staffing incidents/performance reporting.	**On track**
1.g	Must	Child and adolescent mental health wards	The Trust must ensure the improvements made in response to the warning notice are maintained, that it has clear oversight and assurance of all risk issues and that timely action is taken as needed to ensure that young people using the service are kept safe	To have governance processes in place, to review issues raised during the inspection and ensure risks are identified and managed.	Dec-18		Action plan developed July 2018 in immediate response to Warning Notice with ongoing review of progress against issues. Ligature work at Leigh House completed. Bluebird House -agreed plan of transfer for one individual patient (transfer planned July), new staffing model agreed, daily staffing reports and refreshed approach to recruitment, ongoing review of restraint practices across trust, introducing adapted PEWS, safer staffing levels met by agency staff. Ongoing staffing pressures.	**Completed**	Improved experience for patients who receive safe care and treatment.	Safer staffing reports. Overview of reported incidents.	Jan-19		Workforce Development Group in place - planning includes new low secure unit. 12 red flag incidents BBH July 18 to March 19 (all no/low harm impact) 4 red flag incidents Leigh House July 18 to March 19 (all no/low harm) discussed at learning from incident meetings.	**Completed**

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1.h	Should	Acute wards for adults of working age and psychiatric intensive care units (PICU)	The Trust should ensure that all patients have access to therapeutic activities and engagement	**see action 1.e** To plan activity schedules across whole week.	Mar-19		QI project on Kingsley ward included focus on developing more activities and involved service users in planning activity programmes. Learning from project shared with other wards. All wards have activity programmes in place across whole week.	**Completed**	Personalised activities are available to patients based on their need.	Evidence of activity programmes in place. Positive patient feedback.	Dec-19		Some feedback from service users that activities could be more varied. New User Involvement Facilitator is reviewing programmes currently.	**On track**
1.i	Must	Wards for older people with mental health problems	The Trust must ensure patients are supported to use their section 17 leave	To review use of Mental Health Act leave across the Trust and establish why it is not available consistently. To develop and implement a plan to address issues based on findings.	Mar-19		QI project on Kingsley ward included review of Section 17 leave processes with presentation from ward manager to MH Legislation Committee. It was agreed to have a revised section 17 policy specific to Kingsley at this time and to develop a plan to roll out the Kingsley changes to all other units over the next 12 months.	**Complete-Unvalidated**	Improved patient experience through leave being available consistently.	Patient/staff feedback. Reported incidents.	Jun-19		New User Involvement Facilitator for MH services has discussed their experience with service users and is currently collating responses.	**On track**
1.j	Should	Forensic inpatient / secure wards	The Trust should ensure there are enough staff on each shift to meet the needs of all patients. Patients should be able to participate in activities and use their leave even when staff are supporting other wards	**see action 1.i**				**Duplicate**						**Duplicate**
1.k	Should	Forensic inpatient / secure wards	The Trust should ensure that patients access to ground leave are assessed on an individual basis at Ravenswood House Medium Secure Unit and are not subject to blanket restrictions	**see action 1.i**				**Duplicate**						**Duplicate**
1.l	Must	Acute wards for adults of working age and psychiatric intensive care units (PICU)	The Trust must ensure that all staff have access to supervision, team meetings and appraisals as is necessary for them to carry out the duties they are employed to perform	To review supervision practices across the Trust and establish why it is not being accessed consistently and effectively. To develop and implement a model of supervision and guidance to staff based on the findings of the review.	Jul-19		Revised policy/procedure for supervision out for consultation. Revised appraisal template launched April-19 with guidance to staff that it is an opportunity to reflect and focus on their post and personal development. Learning Disability Service Review reviewed supervision practices and proposed improvements.	**On track**	Staff are enabled to be part of meaningful reflective practice and supervision which supports their health and well-being and maintains the safety of patients.	Revised Supervision Policy and Procedures. Positive staff feedback on quality and frequency of supervision. Audit of supervision programme.	Sep-19		Revised supervison policy/procedure will be in place and staff given opportunity to feedback on their experiences of supervision.	**On track**
1.m	Should	Community-based mental health services for adults of working age	The Trust should ensure that relevant staff at the Southampton Central site receive regular clinical supervision in line with Trust policy	**see action 1.l**				**Duplicate**						**Duplicate**
1.n	Should	Community-based mental health services for adults of working age	The Trust should ensure that managers support staff to improve the quality of care plans and use electronic patient record systems appropriately	**see action 1.l**				**Duplicate**						**Duplicate**
1.o	Should	Community-based mental health services for older people	The Trust should ensure managers can clearly demonstrate that staff receive regular supervision	**see action 1.l**				**Duplicate**						**Duplicate**
1.p	Should	Child and adolescent mental health wards	The Trust should ensure that all staff are supervised in line with Trust policy	**see action 1.l**				**Duplicate**						**Duplicate**

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1.q	Should	Forensic inpatient / secure wards	The Trust should ensure management supervision and yearly appraisals are recorded in line with Trust's policy	**see action 1.l**				**Duplicate**						**Duplicate**
1.r	Should	Mental health crisis services and health based places of safety	Ensure staff members receive regular one to one managerial supervision in line with the Trusts policy	**see action 1.l**				**Duplicate**						**Duplicate**
1.s	Should	Wards for older people with mental health problems	The Trust should ensure that poor staff performance is managed effectively	**see action 1.l**				**Duplicate**						**Duplicate**
1.t	Should	Wards for older people with mental health problems	The Trust should ensure that staff receive appropriate and effective supervision within the timescales of the Trust policy	**see action 1.l**				**Duplicate**						**Duplicate**
1.u	Should	Forensic inpatient / secure wards	The Trust should ensure that staff are provided a bully and harassment free working environment to work in	To have visible senior leadership and mechanisms in place enabling staff to feel confident in raising concerns.	Dec-18		Service manager is visible and facilitates monthly open forums for both staff and service users. Staff feedback boxes in place plus a 'graffiti board' which both staff and service users can use to post feedback.	**Completed**	Staff are confident they are listened to when raising issues to managers.	Staff feedback.	Dec-18		Open forums in place. A 'back to the floor' programme developed where nursing leads spend time on the wards giving opportunity for staff discussion/feedback.	**Completed**
1.v	Should	Wards for older people with mental health problems	The Trust should ensure all staff are safely orientated to the ward	To review local induction programme for new staff.	Dec-18		Revised local induction programme in place across all OPMH wards. Trust wide QI project also taking place on local induction.	**Completed**	New staff feel welcomed to the Trust and understand their roles and responsibilities.	Staff feedback on local induction.	Dec-18		Sample of new staff who started Dec-18 to Mar-19 gave positive feedback on their local induction and felt very well supported and that they understood their role and expectations of them.	**Completed**
1.w	Should	Community mental health services for people with a learning disability or autism	The Trust should ensure change is managed appropriately and minimise the impact of change on staff	To explore and address issues raised by staff and continue the 'open door' sessions.	Mar-19		In Feb-19 there were 2 x 5 day Quality Improvement workshops for the Learning Disability Service Review. Summary outputs of QI workshops posted each day so all staff could read and have input into shaping revised services. Ongoing proactive engagement with staff on QI project and at team meetings.	**Completed**	Health and well-being of staff are supported.	You said, we did' feedback. Staff feedback	Apr-19		LD service review included change process and had wide staff engagement. Team meetings show that managers discuss issues with staff.	**Completed**
1.x	Should	Community health inpatient services	The Trust should improve the collection of and complete the actions from clinical audit data results to improve the	To review and streamline clinical audit processes using quality improvement methodology.	Mar-19	Apr-19	Clinical audit QI project started in Apr-19 with workshop proposing improvements to audit programme and processes with oversight of progress by Clinical Effectiveness Group.	**Completed**	Clinical audit leads to improvements in patient care.	Re-audit results demonstrate quality improvements.	Dec-19		Review effectiveness of changes made to audit programme and processes.	**On track**
2.a	Must	Wards for older people with mental health problems	The Trust must ensure that staff apply the Mental Capacity Act if there is doubt about a patient's capacity to consent to admission	To review use of the Mental Capacity Act across the Trust and establish why it is not being applied consistently. To develop and implement a plan to address issues based on findings of the review. To strengthen the operational use of the Mental Capacity Act Policy.	Jun-19		Corporate safeguarding team provided additional support and training to staff at Western Hospital. Thematic review of MCA/DOLS presented to MH Legislation Committee. MCA audit completed and identified improvements required re training and knowledge sharing. Currently MCA training is included as part of safeguarding training. Proposal to have mandatory stand alone scenario based MCA training has been approved and is in development. Aim to support staff putting training into practice with opportunity to discuss complex cases.	**On track**	A patient's mental capacity is appropriately assessed and documented by staff who are knowledgeable and competent in applying the MCA.	Audit use of Mental Capacity Act (MCA). Quality Assessment Tool results.	Aug-19		MCA audit report completed with implementation plan to address issues in development. Progress with actions will be monitored at the Safeguarding Forum.	**On track**

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2.b	Should	Community mental health services for people with a learning disability or autism	The Trust should complete and document Mental Capacity Act assessments when they are required, for example, when making best interest decisions or providing treatment without a patient's consent.	**see action 2.a**				**Duplicate**						**Duplicate**
2.c	Should	Child and adolescent mental health wards	The Trust should ensure that staff are aware of how to assess mental capacity and are aware of Gillick Competency when working with young people.	**see action 2.a** To confirm that agencies providing staff for CAMHS include Gillick competency in their training programmes.	Mar-19		Bluebird House and Leigh House completed own training programme on Gillick Competency. MCA/Gillick competency in Level 2 and 3 safeguarding training within trust. Corporate safeguarding team have reviewed and confirmed all agencies supplying staff include Gillick competencies in their training and that it is to same standard as Trust training.	**Completed**	The Trust has assurance that agency staff are trained to the same level of competency as substantive staff.	Agency training programmes include Gillick competency. Audit use of Mental Capacity Act.	Aug-19		Spot check audit planned for July to ensure all staff in a set timeframe understand Gillick competency. Will include off framework agency staff.	**Complete-Unvalidated**
2.d	Should	Wards for older people with mental health problems	The Trust should monitor the use of the Mental Capacity Act	To review the current governance structures for the oversight of the Mental Capacity Act. To develop and present for approval a proposal for the operational, governance and reporting processes for the Mental Capacity Act across the Trust. To develop and implement	Jun-19		Executive have approved proposal to have a separate MCA/DOLS team which is not part of the corporate safeguarding team as is the case at present. Scoping underway at present for MCA/DOLS team on similar basis to MHA admin team ie have a co-ordinator and administrator.	**On track**	There will be oversight of all patients assessed under the Mental Capacity Act with agreed reporting and monitoring processes across the Trust.	Proposal and implementation plan.	Sep-19		MCA/DOLS information often recorded on paper and analysis done manually. Electronic patient record (RiO) has elements that could be used to record MCA electronically which would make overview and analysis easier. Trust working with UHS and Solent to look at how we can have a more integrated model across trusts.	**On track**
2.e	Must	Wards for older people with mental health problems	The Trust must ensure safeguarding concerns are raised with the local authority	To amend systems to enable recording and oversight of safeguarding referrals to the Local Authority. To strengthen the operational use of the Safeguarding Policy and Procedures.	Mar-19		Electronic reporting system Ulysses amended so that safeguarding referrals to Local Authority can be recorded, including LADO and SAMA referrrals (allegations against staff). Safeguarding team have provided additional support and training to staff at Western Hospital. Safeguarding 'hotspots' posters reminds staff re their responsibilities to refer if safeguarding concerns. Safeguarding Adults Policy v11 and Safeguarding Children's Policy v5 have been reviewed and updated to reflect any local and national changes.	**Completed**	The safety of patients is supported with safeguarding concerns identified and reported by staff who are knowledgeable and competent in applying the Safeguarding Policy and Procedures.	Sample case audit to ensure that changes to recording systems and knowledge are embedded and understood. Feedback from staff and local authority.	Mar-19	Sep-19	New reporting systems need to embed before appropriate to audit.	**Overdue**
2.f	Should	Community-based mental health services for adults of working age	The Trust should ensure that all staff adhere to the safeguarding policy and raise safeguarding concerns with the relevant local authority	**See action 2.e**				**Duplicate**						**Duplicate**
2.g	Should	Community-based mental health services for adults of working age	The Trust should ensure that the community mental health teams work with the local authorities to safeguard adults at risk.	**See action 2.e**				**Duplicate**						**Duplicate**
2.h	Should	Mental health crisis services and health based places of safety	Ensure managers monitor the number of safeguarding referrals to the local authority	**See action 2.e**				**Duplicate**						**Duplicate**
2.i	Should	Community-based mental health services for adults of working age	The Trust should ensure that the Southampton teams, who are due to re-integrate the team back with adult social services, clarify local	To clarify local safeguarding processes with Southampton City Council.			Action completed prior to development of QIP - evidence presented to Evidence of Improvement Panel.	**Completed**	There are agreed processes in place and staff are clear as to how to raise safeguarding concerns with the Local Authority.	Audit the use of Safeguarding standard operating procedures in Southampton teams.	Aug-19		Action completed prior to development of QIP - evidence presented to Evidence of Improvement Panel.	**Completed**

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2.j	Should	Community health services for children, young people and families	Continue to ensure health reviews for children in care are completed in a timely way.	To review the Children in Care service specification with commissioners and key stakeholders.	May-19		'The Children In Care' (CIC) service specification is under active review with commissioners and stakeholders to ensure the Trust is commissioned and funded to fulfil its obligations and ensure that all Looked after Children receive a health assessment in a timely and equitable way. Changes to completion of health assessments in clinics rather than at home has led to reductions in delays to assessments being completed.	Completed	There will be agreement with commissioners on the service specification with potentially additional resources to enable health reviews to be completed within timeframes or agreement that the timeframes are extended to allow for the extra demand.	Audit that health assessments are completed within agreed timescales/benchmarks. Feedback from users.	Jun-19		Significant improvements to timeliness of health assessments has been maintained over 2-3 months.	On track
3.a	Must	End of Life Care	End of life care must ensure that all do not attempt resuscitation or DNACPR forms are fully completed.	To continue delivery of the End of Life Care Strategy 2016-2020.	Jun-19		DNACPR audits completed every 6 months with improvements seen over time, for example, discussing patients wishes in last few days of life, however improvements still to be made in having early conversations. Chaplain, has completed two workshops on having difficult conversations which over 35 staff attended. Ongoing discussions about the use of 'Respect' form.	On track	**Ambition 1: Each person is seen as individual.** Where appropriate all patients and those important to them will have the opportunity for honest and well-informed conversations about dying, and death.	Confirmed through clinical audit.	Jul-19		Next DNACPR audit due May/June.	On track
3.b	Should	End of Life Care	End of life care should review recording of the prescribing and administration of medicines for patients receiving end of life and palliative care, to ensure	**See action 3.a**	Jun-19		Anticipatory medication audit out for data collection currently.	On track	**Ambition 3: Maximising comfort and well being** Patients and those important to them, where appropriate should feel informed and involved in the management of their medication.	Feedback from patients and those important to them. Participation in two year National EoL audit.	Aug-19		Any required improvements identified by the audit will have a plan to address them.	On track
3.c	Should	End of Life Care	End of life care should ensure there are appropriate arrangements for collecting and reporting on safeguarding referral team's data for patients receiving palliative or care at end of life.	**See action 3.a**	Feb-19		Electronic incident reporting system (Ulysses) revised to enable recording of incidents relating to end of life patients. EOL committee reviewed EOL incidents from July - Dec 2018 and found 2.6% had safeguarding concerns raised. Individual safeguarding incidents discussed at EOLC. A member of the corporate safeguarding team dials into the 48 hour Immediate Management Assessment (IMA) panel and therefore is aware of moderate and above incidents for patients at end of life and will agree any actions that the safeguarding team need to take.	Completed	**Ambition 5: All staff are prepared to care** Any issues that are related to end of life care are quickly identified and responded to through the Trust governance process.	Minutes of End of Life Strategy meeting. Minutes of Caring group meeting.	Feb-19		EOLC has regular report on EOL /safeguarding incidents. 48 hour IMA panels review all moderate and above incidents.	Completed
3.d	Should	End of Life Care	End of life care should review governance of all mortuary fridge temperature checks to establish responsibility and ensure they take place regularly.	To develop and implement standard operating procedures for mortuary monitoring across the Trust.	Jan-19		Standard/bariatric mortuary storage temperature monitoring forms revised and process to monitor these agreed at community hospital sites.	Completed	**Ambition 4: care is coordinated** All mortuaries are monitored and managed inline with manufactory guidelines to ensure the safe storage of patients body whilst they remain in our care.	Confirmed through clinical audit.	Feb-19		Standard/bariatric mortuary storage temperature monitoring forms in place which include procedure to follow if need to raise an issue. Independent remote data logging of mortuary storage temperatures provides additional level of assurance re monitoring.	Complete-Unvalidated
3.e	Should	End of Life Care	End of life care service should review the arrangements for paper based end of life and palliative care guidance held by community and inpatient teams to	**See action 3.a**	May-19		Revised leaflet available at Lymington New Forest Hospital - produced with input from LNFH patient group.Sites also use McMillan leaflets on bereavement.	Completed	**Ambition 1: Each person is treated as an individual** Systems ensure effective assessment, coordination, planning and delivery of care for patients reaching the end of their life.	Feedback from staff, End of Life champions and patient stories.	Jul-19		Draft bereavement survey currently circulated for feedback. Patient stories are part of the EOLC standard agenda.	On track
3.f	Should	End of Life Care	End of life care service should review arrangements for syringe driver training to ensure compliance target set is achieved.	**See action 3.a**	Mar-19		Target compliance within teams is 60%. Currently 82% compliance across teams.	Complete-Unvalidated	**Ambition 5: All staff are prepared to care** Well-trained, competent and confident staff provide, professional, compassionate and skilled care to meet patients needs.	Training results and feedback from patients	Jun-19		Feedback where EOL is the primary category recorded between 05-Jun-18 to 05-Jun-19; - 1 Complaint - 1 Complex complaint - 5 Concerns - 30 Compliments	On track

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3.g	Should	End of Life Care	End of life care should review availability of bereavement advice and information leaflets, so that it is consistent and widely available for patients and their relatives in inpatient and community settings	**See action 3.a**	Jun-19		Working group commenced to review information and link to Carers group established.	On track	**Ambition 6: All communities are prepared to care.** Patients and those important to them will have access to information that provides advice and signposting, resulting in them feeling informed and connected to local services.	Feedback from relatives, carers, friends and staff. Leaflet.	Jul-19		Ongoing review of information.	On track
3.h	Should	End of Life Care	End of life care should review arrangements to gather effective feedback from patients and people receiving end of life or palliative care to ensure service is able to improve informed by patient need.	**See action 3.a**	Jun-19		Ways to gather feedback discussed with Working in Partnership Committee. A draft bereavement survey developed and is currently under consultation.	On track	**Ambition 1: Each person as an individual** Patients and those important to them have a method that they can quickly and easily feedback their experience to us. This will enable us to be more responsive to changes that may need to be made and improve patient experience at the end of life.	Action taken from feedback from patients and those important to them.	Aug-19		Draft bereavement survey developed to gain feedback. Patients/families can raise concerns directly with teams.	On track
3.i	Should	End of Life Care	End of life care should review arrangements for non-executive representation at Trust board level for end of life and palliative care.	**See action 3.a**	Apr-19		Lynne Hunt, Trust Chair, is the non-executive representative for EOLC.	Completed	**Ambition 5: all staff are prepared to care** Provide clear governance at Board level to enable high quality end of life care within the organisation.	Minutes of Board meetings.	Aug-19		Lynne Hunt to attend EOLC and visit some teams.	On track
3.j	Should	End of Life Care	End of life care should review arrangements for ensuring all staff are aware of who the leads for end of life care are.	**See action 3.a**	Jul-19		Staff website has been updated.	On track	**Ambition 4: care is coordinated** Organisational leadership is joined up in a way that provides a clear oversight for patients and staff of the respective roles and responsibilities for end of life care.	Staff feedback.	Jul-19		Staff website has been updated.	On track
3.k	Should	End of Life Care	End of life care should review arrangements for the reporting and governance of all meetings and decision making representing end of life and palliative care.	**See action 3.a**	Apr-19		Clear reporting schedule in place for EOL reports to be submitted to both the Caring Group and to Board. EOL committee meets bimonthly and has ToR and standard agenda. Complaints: EOL is being recorded as initial category and forwarded to EOL lead so latter has overview of issues raised. Incidents: EOL recorded on Ulysses so able to pull information on all EOL incidents for review/learning. ERP validated action as completed.	Completed	**Ambition 5 All staff are prepared to care.** Clear governance lines in place to ensure prompt response to issues raised enabling share learning and continued improvements in care are made.	Patient and staff feedback. Annual Board Report.	Apr-19		Results of national EOL audit indicates good governance in place for EOL. National audit found Trust (10.0) comparing well to national ratings (9.5). Trust met all requirements re governance including: -Identified member of Trust Board with responsibility for EOL care -Specific care arrangements to enable rapid discharge home to die if this is person's preference -A care plan to support the five priorities for care for the dying person	Completed
4.a	Must	Community-based mental health services for adults of working age	The Trust must ensure that patients have a current care plan, that is person-centred, holistic and recovery orientated	To review the use of care plans across the Trust and establish why care plans are not always up to date, personalised, developed in partnership, or copies offered to patients/carers. To develop and implement plans to address issues based on review findings.	Jun-19		QI project focusing on care plans underway with improvements to be rolled out across trust following pilot.. AMH launched 'care plan on a page' earlier this year making it simpler to see care needs in one place. Trust wide Records Keeping Group has oversight of progress with improvements to care plans.	On track	Patients have a care plan that is up to date, personalised and where possible has been developed in partnership with them or their carers. Patients are offered copies of their care plan which outlines their goals and/or treatment aims. Staff understand their responsibilities and are clear on how to develop, record and store care plans.	Sample audit of care plans. Patient/carer/staff feedback. Quality Assessment Tool and peer review results.	Sep-19		Audit to be carried out, review peer review and Quality Assessment Tool results.	On track

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4.b	Must	Mental health crisis services and health based places of safety	The Trust must ensure that staff members in the crisis teams ensure patients have care plans that are up to date and comprehensive. ii)Staff members from the health and safety place of safety must ensure the ambulance provider working in the 136 suite has access to up to date, accurate and comprehensive information about patients in their care and treatment plans.	**see action 4.a** To clarify how care plans / 'immediate plan of care' for patients in 136 suites are developed and used consistently across the Trust. To ensure information is available to all services involved in the patients care.	Mar-19		NB: not all patients will be known to the trust in 136 suites. Irrespective of whether the patient is known to the Trust or not, there will be a discussion between the nurse in charge and secure care with an immediate plan of care completed. This will be an observation care plan and will also include any other requirements. Guidance is given in SH CP 163 Multi-agency Operational Policy for 136 suites.	**Complete-Unvalidated**	Patients safety and care is supported by having up to date care/crisis plans and/or 'immediate plan of care' agreed and available to all services involved.	Guidance on 'immediate plan of care'. Sample audit of care plans. Service User feedback.	Sep-19		Audit and feedback to be planned.	**On track**
4.c	Should	Community-based mental health services for adults of working age	The Trust should ensure that staff always offer patients a copy of their care plan, and document they have done so	**see action 4.a**				**Duplicate**						**Duplicate**
4.d	Should	Community-based mental health services for adults of working age	The Trust should ensure that care plans are easily accessible and that staff save them in the correct place in the electronic systems. In addition, the Trust should ensure that when paper copies of patient records are used these are kept up to date.	**see action 4.a**				**Duplicate**						**Duplicate**
4.e	Should	Community mental health services for people with a learning disability or autism	The Trust should record whether or not patients have been offered a copy of their care plans	**see action 4.a**				**Duplicate**						**Duplicate**
4.f	Should	Community-based mental health services for older people	The Trust should ensure that staff always offer patients a copy of their care plan, and document they have done so	**see action 4.a**				**Duplicate**						**Duplicate**
4.g	Should	Forensic inpatient / secure wards	The Trust should ensure care plans are personalised and ensure that staff involve patients in the care planning process. Care plans should be based on the patient's goals and a copy should be given to the patient	**see action 4.a**				**Duplicate**						**Duplicate**
4.h	Should	Community-based mental health services for older people	The Trust should ensure that patient risk assessments are regularly updated in patient records	**see action 4.a**				**Duplicate**						**Duplicate**

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4.i	Must	Mental health crisis services and health based places of safety	The Trust must ensure that staff members from the health based place of safety service collects and uses information well to support all its activities. Senior Trust members should have full access to information concerning the 24 breaches (patients, who have been not been given an extension by an approved person must not be detained more than 24 hours in the health based place of safety) exceeding the maximum detention period in the health based place of safety. They must ensure there are effective governance systems in place.	To report all section 136 breaches reported as incident and discussed at IMA panel. To invite stakeholders (CCG, AMHP, police, secure care) for discussion of every breach. To report breaches to Mental Health Act Committee.			All 136 suite breaches are recorded as incidents and discussed at 48 hour IMA panel. External stakeholders e.g. police invited to IMA panels. IMA checks details of incident and adds narrative to incident and confirms whether a breach or not. All breaches are discussed at Pan Hampshire 136 suite meeting and also at divisional performance meetings.	**Completed**	Oversight and understanding of reasons for 136 breaches leads to improved practice and experience for the patient.	Audit of IMA panel evidence.	Mar-19		A monthly multi-agency S136 meeting reviews all the breaches. Meeting is attended by commissioners, secure care and the Trust. Quality Governance Business Partner reviews all reported breaches each month to review for themes and learning. Cluster serious incident investigation into 136 breaches is underway.	**Complete-Unvalidated**
4.j	Must	Community health inpatient services	The Trust must ensure all records are stored securely across all hospital sites.	To review records management across the Trust and establish why the Record Keeping Policy and Procedures are not always followed. To develop and implement plans to address issues based on the review findings.	May-19		All community hospitals have checked thier records storage on site meets standards and have ordered new equipment where needed eg put key code locks on office doors, amended records trollies so can be locked.	**Complete-Unvalidated**	Patient clinical records have up to date information, meet the quality standards set by the Trust and are stored safely.	Sample audit of records. Quality Assessment Tool and peer review results.	Sep-19		Audit to be planned.	**On track**
4.k	Should	Acute wards for adults of working age and psychiatric intensive care units (PICU)	The Trust should ensure that all the wards at Antelope House have clear seclusion records detailing which ward is using the seclusion room.	To revise guidance on recording the use of seclusion rooms and review seclusion information across the Trust.	Dec-18		Seclusion records reviewed weekly at safeguarding meetings/monthly at Key Quality Indicator meetings therefore oversight of use/trends is in place. Seclusion Trust Guidance SH CP 107 Seclusion Policy v8, Seclusion Flowchart SH CP 107 v8 in place.	**Completed**	Standard reporting on the use of seclusion will provide improved oversight of the use and trends in seclusion.	Review of seclusion records at Key Quality Indicator meetings. Review of seclusion data.	Mar-19		Seclusion records are reviewed at monthly Quality Governance MH meeting and overview of seclusion incidents and any trends is included in the MH divisional report to Quality and Safety Committee.	**Completed**
4.l	Should	Mental health crisis services and health based places of safety	Ensure that staff follow the requirements of the revised Mental Health Act 1983 Code of Practice 2015 and collect information about patient's ethnicity on monitoring forms. They should ensure staff members follow their own policy about the frequency of visits to the health based place of safety and complete a record of these visits to ensure patients safety	To add protected characteristics to monitoring form.			136 Task and Finish group added protected characteristics to monitoring form. Discussed at Pan Hampshire 136 meeting.	**Completed**	The Trust meets the requirements of the MHA Code of Practice.	Pan Hampshire 136 meeting minutes. Audit use of amended monitoring form.	Jun-19		Pan Hampshire 136 meeting reviews progress with protected characteristics.	**On track**

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4.m	Should	Wards for older people with mental health problems	The Trust should ensure that once patients have received their rights, the records are maintained and accessible to staff	**see action 4.j** To review recording of MHA across the Trust and ensure MHA requirements are met.	Dec-18		The MHA administration team send a weekly reminder re 132 rights/MHA requirements to ward managers to flag all patients and ensure compliance. Any breaches are recorded as incidents - sometimes this is due to current paper based system not being robust. Aim is to add 132 rights form onto electronic patient record. MHA inspection of Berrywood ward positive with no actions required. OPMH matrons have worked with MHA administrators at Western Hospital re processes.	**Complete-Unvalidated**	Patient clinical records have up to date information, meet the quality standards set by the Trust and are stored safely. Requirements of the MHA are met by staff who are knowledgeable and competent in applying the MHA.	MHA records audit	Dec-18		Current system in place for monitoring, regular provision and recording of patients rights, consisting of a section 132 form documenting when rights have been provided; a weekly MHA monitoring spreadsheet advising clinical teams when MHA requirements are due. These are followed up by the MHA Administration team.	**Complete-Unvalidated**
4.n	Should	Community health services for adults	Continue their work to improve the access, completion and updating of patient records	**see action 4.j** To ensure all community health teams have access to 'Store and Forward' on laptops.	Apr-19		All staff offered options of using store and forward or using 3G to record information remotely whichever is most appropriate depending on the area.	**Completed**	Patient clinical records have up to date information, meet the quality standards set by the Trust and are stored safely.	Tableau report on Store and Forward.	Apr-19		Confirm teams can access either store and forward or 3G. Matron checking records are recorded contemporaneously via RiO report.	**Completed**
5.a	Must	Wards for older people with mental health problems	The Trust must ensure that medication is stored at the correct temperature on all wards	To identify the clinic rooms across the Trust where the temperatures were not appropriate for storage of medicines. To develop and implement plan for storage of medicines in temperature controlled environments.	Jul-19		All teams are recording incidents where temperatures are over 25 degrees in clinic rooms storing medicines. Sometimes intermittent eg heat wave and others where rooms are consistently too hot. Estates and medicine management teams have a task and finish group to address issues. Estates are fitting temperature records devices inside drugs cupboards to provide alert. Interim measures taken re medicines - in August 2018 destroyed all stock medicines with expiry date in 2018. Added labels for remaining stock - to reduce expiry date by 6 months. To have a formal process to review medicines where temperatures over 25 degrees.	**On track**	Patient safety will be improved by patients receiving medicines which have been stored at the correct temperature.	Incident data from Ulysses. Implementation plan completed. Quality Assessment Tool results.	Sep-19		Process in place to ensure medicines are stored at correct temperatures.	**On track**
5.b	Must	Community health inpatient services	The Trust must ensure all medicines are stored safely and in in line with the manufacturers guidelines	To amend the Medicines Control, Administration and Prescribing Policy to stop re-use of medicines. To strengthen the operational use of the Medicines Control, Administration and Prescribing Policy. To send INTERNAL safety alert to services to highlight action required.	**Completed**		Policy amended immediately during CQC inspection and CAS alert circulated to stop re-use of medicines.	**Completed**	Patient safety will be improved by patients receiving medicines which have been safely stored and used in line with policy and procedures.	Annual safe and secure handling of medicines audit	Jun-19		Pharmacy technicians will complete checks on wards they cover in May re re-use of medicines - to feedback results.	**On track**
5.c	Should	Community-based mental health services for older people	The Trust should ensure medicines are stored within temperatures according to manufacturer's recommendation	**see action 5.a**				**Duplicate**						**Duplicate**
5.d	Should	Community-based mental health services for adults of working age	The Trust should ensure that in Southampton Central site, patient's medication records only contain the current medication prescription	**see action 5.b (operational use of MCAPP)** To audit correct use of prescription records.	Dec-18		Lead has contacted all consultants in Southampton to make sure medication charts are completed accurately. Audit in December found improvements still to be made so re-audit completed after 3 months and found improvements achieved.	**Completed**	Patient safety will be improved by patients receiving the appropriate medicines recorded on up to date prescription records.	Audit of prescription records shows appropriate recording.	Dec-18	May-19	Re-audit (30 patients) in March found significant improvement showing only 1 prescription didn't have old prescription crossed out and 1 not having the dates before/after the depot should be given. Re-audit indicates that have appropriate training for medical colleagues, and this will continue to be monitored by appropriate audits when required. There are also systems now in all CMHT physical health clinics to ensure forms are appropriately completed.	**Completed**

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5.e	Should	Community-based mental health services for adults of working age	The Trust should ensure that all patients prescribed Clozapine have a relevant medication care plan in line with Trust policy.	To strengthen operational use of the Trusts guidance on clozapine.	Jan-19	Apr-19	Patients on clozapine attend a physical health clinic run by one of the Community Mental Health Teams (CMHT). The patient also retains their care co-ordinator from their 'home' CMHT. There was misunderstanding as to who updated the care plan. This has been resolved and audits (30 patients in April, 30 in May) are showing improvements in number of updated plans and their quality.	Completed	Patient safety will be improved by patients receiving clozapine in line with Trust guidance.	Audit use of clozapine.	Mar-19	Jun-19	Rol out of care plan on a page delayed this action. Re-audit planned for June and aim for action to be completed if improvements sustained.	Overdue
5.f	Should	Urgent Care	Undertake appropriate recording of stock checks of prescription	To audit use of prescription forms.			Immediate LNFH FP10 audit at time of CQC inspection found 1 x human error incident.	Completed	Safe medicines management	FP10 audit results.			Repeat FP10 audits show compliance.	Completed
5.g	Should	Community health services for children, young people and families	Ensure medicines are managed to a consistently high standard across all service areas, including special schools	To ensure safe medicines management in schools in line with Hampshire County Council (HCC) guidance.			HR/RCA investigation completed and learning shared. Support to Head teacher re dialogue with commissioners about the service commissioned. Notice has already been given on this contract.	Completed	Safe medicines management in schools in line with HCC guidance.	The nurse will not administer medication in Special Schools but will support Special School staff to administer medication.			all actions completed.	Completed
5.h	Should	Community health Inpatient Services	Transferred from 2017 CQC IAP (57.2 and 57.3) The trust should ensure that staff support and enable patients to administer their medicines as part of the discharge process in the rehabilitation wards.	To implement Self Administration Policy on wards with risk assessment of wards and individual patients completed.	May-19		Self-administration of medicines pilot delayed due to staff availability. Pilots now started at Romsey and GWMH hospitals. Results will be analysed for September.	Complete-Unvalidated	Patients will have support to self administer medicines safely and effectively.	Audit self-administration of medicines.	Aug-19		Roll out across trust delayed due to delay in pilots.	At risk
6.a	Must	Wards for older people with mental health problems	The Trust must ensure that all wards have a dedicated female-only room which male patients do not enter	To ensure compliance with standards of gender separation across the Trust.	Jan-19	Jul-19	Proposal to address gender segregation in OPMH wards submitted to Senior Management Committee and Quality and Safety Committee. Options are currently being considered. Existing environment at GWMH means there are limited options. Beaulieu re-opened in June with female only lounge and clear female/male sections to ward. Work on Berrywood and SOU to start in June. To have a Task and Finish group to review all of OPMH services including bed stock and bed options.	Overdue	There will be access to gender specific areas across all inpatient sites.	Review of compliance in inpatient areas.	Apr-19		Progress dependent on outcome of task and finish group with recovery date to be agreed.	Overdue
6.b	Must	Wards for older people with mental health problems	The Trust must ensure there are rooms available for patients to meet their visitors in private and ensure patients are able to make phone calls in private	To amend 'inpatient welcome packs' to include information on opportunity to talk in private.	Nov-18		All OPMH welcome packs to wards include information on requesting to make a phone call in private or to meet in private.	Completed	Patients and families are available to meet and have phone calls in private.	Revised Welcome Packs. Patient/Family feedback.	Mar-19		All OPMH welcome packs to wards include information on requesting to make a phone call in private or to meet in private.	Completed
6.c	Must	Community health inpatient services	The Trust must improve the privacy and dignity of patients at Romsey hospital	To ensure privacy and dignity, we will work with our commissioners to reduce bed capacity at Romsey hospital.	Jun-19		Agreed with commissioners, League of Friends, other stakeholders to transfer 4 beds to LNFH.	On track	Patients privacy and dignity are maintained.	Proposal for environment at Romsey Hospital. Progress with improvement plan.	Jul-19		Date to be agreed re transfer of beds to LNFH.	On track
6.d	Must	Child and adolescent mental health wards (CAMHS)	The Trust must ensure that prone restraint is only used as a last resort and continue work on minimising the use of prone restraint	To participate in a two year national programme to reduce restrictive practices in inpatient CAMHS.	Sep-19		Project underway to review restraint practices across trust.	On track	Improved patient experience on CAMHS wards. Improved health and well-being of staff.	Reduced incidents of restraint. Patient and staff feedback.	Oct-20		Trust is part of national programme which will report in 2020.	On track
6.e	Should	Forensic inpatient / secure wards	The Trust should ensure there are adapted bathroom and toilet facilities for people with physical disabilities at both Ravenswood House Medium Secure Unit and Southfields Low Secure Unit for people	To ensure compliance with Disability Discrimination Act.	Sep-19		Capital bid for bathrooms works agreed.	On track	Improved consideration to physical needs and improved environment to meet DDA regulations.	Future redevelopment plans to include adapted bathrooms. Review inpatient areas. Patient feedback.	Oct-19		Capital bid for bathrooms works agreed.	On track

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6.f	Should	Mental health crisis services and health based places of safety	Ensure the toilet door in the section 136 suite at Antelope House is replaced quickly	To review appropriateness of current toilet door which is locked back.	Nov-18		Door was locked back flush into wall. Estates confirmed door could be locked/unlocked.	Completed	Patients privacy and dignity are maintained.	If review finds the locked back door is not appropriate then alternate solution to be agreed. Patient feedback.	Dec-18		Toilet door is now able to be unlocked from its position flush to the wall and so can be used which maintains patients privacy and dignity.	Completed
6.g	Should	Wards for older people with mental health problems	The Trust should ensure that patient privacy and dignity is prioritised at all times even if they do not have their own bedrooms	**see action 6.a**	Jan-19	Jul-19	see action 6.a	Overdue	There will be access to gender specific areas across all inpatient sites.	Review of compliance in inpatient areas.	Apr-19		see action 6a.	Overdue
6.h	Should	Wards for older people with mental health problems	The Trust should continue to develop the dementia friendly environments on the organic wards	To continue programme to provide dementia friendly environments in inpatient areas.	May-19		Dementia Friendly environmental plan in place with ongoing works completed. Dementia Environment Group is overseeing this work, reporting to Dementia Strategy Steering Group; new dementia strategy focusses closely on the provision of dementia friendly environments. Continue to be assessed by PLACE whilst pursuing accreditation by various bodies including AIMS and the 'Dementia Friendly Hospital Charter' . Beaulieu ward re-opened in June and is dementia friendly.	Completed	Patients have an improved experience in dementia friendly environments which better meet their needs.	Progress with PLACE/Estates plan to provide dementia friendly environments. PLACE feedback. Carers and family feedback.	Jul-19		Working in Partnership Committee prioritising requests from Place audits to feed into dementia friendly programme.	On track
6.i	Should	Community-based mental health services for older people	The Trust should review the pathway to access crisis response for this patient group	To develop and implement a needs led strategy for Older People's Mental Health services.	Jul-19		There will be one business plan for MH with focus on moving towards age less service.In South East Hampshire the crisis pathway project started in AMH with OPMH now linked into this project. Case by case support for OPMH patients continues from AMH consultants while new pathways are being agreed.	On track	Patients have access to crisis pathways based on their needs.	OPMH strategy and implementation plan.	Aug-19		Crisis pathway for OPMH patients will be in place.	On track
6.j	Should	Community-based mental health services for older people	The Trust should review the provision of office space for the Gosport, New Forest East and Parklands CMHT	**see action 6.i** To review CMHT office provision. The OPMH strategy will include a review of estates provision.	Jan-19		Parklands CMHT moved into bigger offices. Gosport CMHT at Aerodrome House has sufficient office space. Ongoing work on New Forest CMHT office space.	Complete-Unvalidated	Changes to estates provision will enable staff to carry out their roles more effectively.	OPMH strategy and implementation plan.	Mar-19		Office moves already made for some teams. New divisional structures within trust may bring more changes.	Complete-Unvalidated
7.a	Should	Urgent Care	Undertake appropriate recording of clinical competency books given to advance nurse practitioners	To discuss clinical competencies at 1 to 1s and appraisals with staff.			Action completed prior to submission of plan to CQC.	Completed	Staff are supported to complete and record clinical competencies.	Clinical competency books are completed.	Completed		Action completed prior to submission of plan to CQC.	Completed
7.b	Should	Community-based mental health services for adults of working age	The Trust should mitigate the risk posed by the location of the clinic room at the Petersfield site	To remodel use of rooms at Petersfield hospital which will mitigate lone working risk.			Clinic room is not being used until remodelling of site - therefore removed risk re lone working.	Completed	Health and well-being of staff are supported.	Progress update with Petersfield hospital remodelling plans.	Dec-19		Petersfield Hospital plans will be clearer.	On track
7.c	Should	Community health inpatient services	The Trust should ensure staff are always able to deliver safe care at night at Romsey hospital	To review current staffing levels and the environment at Romsey hospital to ensure safe patient care.	Feb-19		There was model of 2 RNs and 1 HCSW on duty at night when CQC carried out inspection. Following their inspection increased the staffing to 2 RNs and 2 HCSWs on duty at night to ensure sight of all patients at Romsey Hospital.	Completed	Patients will receive safe care at night.	Safer staffing reports. Staff feedback on environment at Romsey hospital.	Feb-19		Has been 1 red flag staffing incident in Dec 2018.	Completed
7.d	Should	Urgent Care	Continue its plans to reconfigure the Minor Injury Unit at Petersfield Hospital	To complete reconfiguration plans for the Minor Injury Unit at Petersfield hospital.	Dec-18		Reconfiguration plans in place with MIU in first phase.	Completed	Patients will have an improved experience and safe care in an appropriate environment.	Reconfigured MIU at Petersfield hospital - site visit/photographs.	Dec-19		Need confirmation of approval of reconfiguration plans.	On track

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7.e	Should	Community health services for adults	Ensure service provision at Hythe Hospital can i) meet patient needs and ii) the environment meets infection and prevention control guidelines	To communicate in advance to patients and other key stakeholders any closures to the walk in X-ray service. To ensure the environment at Hythe hospital meets Trust Infection, Control and Prevention standards.	Jan-19		Hythe hospital only able to provide limited X ray service - information circulated widely to patients, GPs, practice staff. Radiology curtain replaced and Infection Prevention na dControl Nurse has made several visits to check standards.	Completed	Hythe hospital is compliant with IPC requirements in line with IPC Policy and Procedures.	Replacement programme for curtains. Site visit to Hythe hospital.	Jan-19		Hythe Hospital is being refitted therefore some of actions dependent on timing of building works. Replacement curtain process in place.	Completed
7.f	Should	Community mental health services for people with a learning disability or autism	The Trust should progress action to resolve information technology connectivity issues on two of the	To review alternate accommodation and move staff where possible.	Mar-19		Teams moved from HCC premises to Trust premises to ease IT issues.One team unable to move at present has been alloacted desks at local hospital site.	Completed	Changes to accommodation will enable staff to better carry out their roles.	Progress with project plan.	Jun-19		Teams moved from HCC premises to Trust premises to ease IT issues.	Completed
7.g	Should	Community-based mental health services for adults of working age	The Trust should ensure that mobile phones given to staff to use in the community are fit for purpose	To renegotiate contract with mobile telephone provider and consider upgrades to existing mobile phones.	Apr-19		Mobile phone contract renegotiated and contract awarded. Upgrade of mobiles to smart phones.	Completed	Community staff have mobile phones which are fit for purpose.	Contract renegotiation and agreed future provision.	Apr-19		Current mobile phones meet policy standards for lone working.	Complete-Unvalidated
7.h	Should	Wards for older people with mental health problems	The Trust should ensure all staff are issued with personal alarms	To review current security systems across OPMH wards and implement plan to address issues.	Dec-18	Apr-19	Personal alarms now available for all staff on wards, including cleaners.	Complete-Unvalidated	Security systems are in place on OPMH wards which enable staff to feel and be safe.	Staff feedback. Security systems in place.	Dec-18	Jul-19	Need to embed process for giving out and returning alarms.	Overdue
7.i	Should	Wards for older people with mental health problems	The Trust should ensure that equipment is maintained	To strengthen the operational use of the Medical Device Management Policy and Toolkit.	Jan-19		Regular meeitng with equipment suppliers which raise issues and themes re equipment.	Completed	Staff understand their responsibilities and are clear on the procedures to follow to maintain equipment safely.	Peer review of inpatient sites. Maintenance logs for equipment.	Feb-19		Peer review of inpatient sites is ongoing to check equipment maintenance and cleanliness.	Complete-Unvalidated
7.j	Should	Community health services for adults	Continue their work to improve the timeliness of equipment provision with external providers	To continue liaison with external providers to improve equipment provision with issues continued to be raised with commissioners.	Apr-19		Medical Devices Forum - Regular high level meetings with Millbrook and Hampshire Equipment Stores /commissioners to discuss issues. Reduced number of issues.	Completed	Equipment is available based on the patient's needs.	Information on reported incidents. Minutes of meetings with commissioners/external providers.	Apr-19		Medical Devices Forum - Regular high level meetings with Millbrook and Hampshire Equipment Stores /commissioners to discuss issues. Reduced number of issues.	Completed
7.k	Should	Forensic inpatient / secure wards	The Trust should ensure patients are offered a variety of food, taking account special dietary requirement such as veganism	To develop and offer a wider range of food options for restricted diets.	Apr-19		Increased range of food options discussed and agreed with service users - to include vegan and non gluten options. Standardised the labelling of foods on menus so easier to raed.	Completed	Improved patient satisfaction with food choices.	Patient satisfaction feedback. Menu choices for restricted diets.	Jun-19		Feedback from Ravenswood patients on food experience in April - 'what do you think of the food at Ravenswood? - lots of positive comments and a few things not working so well. Suggestions for improvements made. Plans to address issues already proposed. 14.05.19 ' I would like to Thank you to you all for your hard work in making today's Curry and Chaat for Mental Health Awareness Week a great success. It was so nice to see the increase in attendance at the canteen and staff and patients socialising together. We have received positive feedback from both patients and staff.'	Completed
7.l	Should	Mental health crisis services and health based places of safety	Ensure the staff team seek feedback from patients who have used the health based place of safety	To research independent ways of gathering feedback to improve services.	Feb-19		The Hampshire and the Isle of Wight (HIoW) s136 Multi-Agency Meeting group will oversee the delivery of the S136 and S135 crisis care provision across the geography, and will provide a forum to promote effective multiagency whole system planning to improve outcomes for 'all age' crisis care provision, their families, carers and other professionals involved. The group will be responsible for the delivery of improvements to the s136 pathway as specified by the HIoW regional Crisis Care Concordat group.	Completed	Use of independent feedback to improve our services.	Evidence of improvements made.	May-19		Trust looking into independent company to carry out the Friends and Family Test. New User Involvement Facilitator has completed audits re feedback from service users and has presented to Board. Cluster SI of 136 breaches will offer opportunity for patients/family to provide feedback on their experience.	Complete-Unvalidated

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7.m	Should	Wards for older people with mental health problems	The Trust should ensure that complaints are investigated within the timescales set out by the Trust	To review complaints processes across the Trust and establish why response targets are not met. To strengthen the operational use of the Complaints Policy and Procedures.	Mar-19		Complaints QI project started Mar-19 with analysis of reasons why response times not met and proposed improvements to complaints management process made. Revised process implemented from 1 April.	Completed	Increased satisfaction of complainants with the Trust response to their complaint.	Complaints Performance. Positive complaint satisfaction surveys.	Mar-19	Sep-19	Revised process showing improvements with increase in numbers of complaints addressed within agreed timeframe with 62% sent in May compared to 33% in April.	Overdue
7.n	Should	Community health services for adults	The investigation of complaints to be completed fully and complaints responded to in line with Trust policy	**see action 7.m**			*Refer to the Patient Engagement Improvement Plan*	Duplicate						Duplicate
7.o	Must	Community health inpatient services	The Trust must ensure all staff are up to date with their basic and immediate life support	To ensure training compliance in basic and immediate life support.	Apr-19		Resuscitation training figures May : 89.9%. New electronic staff record system is being applied to tableau reporting including training data therefore check training figures again once completed.	Complete-Unvalidated	Patients safety is improved by having staff who are knowledgeable and competent in life support.	Training compliance.	Apr-19		New electronic staff record system is being applied to tableau reporting including training data therefore check training figures again once completed.	Complete-Unvalidated
7.p	Should	Acute wards for adults of working age and psychiatric intensive care units (PICU)	The Trust should ensure that all staff on Kingsley are trained in physical interventions and restraint so that appropriate support can be provided on Melbury Lodge when needed.	To ensure sufficient numbers of staff are trained in physical intervention to enable appropriate support across inpatient areas when needed.	Feb-19		OPMH staff at Melbury Lodge completed sSs (physical restraint training).	Completed	Staff feel safe and supported by colleagues who have attended specific physical intervention training.	sSs training compliance. Staff feedback.	Apr-19		Staff are offered support following incidents by specialist team. Review of physical restraint training which includes staff feedback is underway.	Complete-Unvalidated
7.q	Should	Community-based mental health services for adults of working age	The Trust should ensure that the Basingstoke site can account for all patients currently on the waiting list and their allocation status	To review referrals, caseloads and waiting times and develop a standard procedure to monitor waiting lists.	Apr-19		Waiting times are monitored closely with a weekly performance report from business support manager to service managers for their attention. Includes tableau report on waiting time data and numbers of patients waiting over 7 weeks. Waiting times and other performance information reviewed at monthly management meeting.	Completed	Patients have an improved experience by receiving an initial assessment within the Trust targets.	Information on waiting times.	Jun-19		Continued monitoring of waiting times to ensure performance targets met.	On track
7.r	Should	Community mental health services for people with a learning disability or autism	The Trust should address the waiting times of up to six months for specific interventions such as dementia assessments and physiotherapy in West Hampshire, art therapy and occupational therapy in Southampton	To review and understand the waiting times for specific interventions/professions. To implement effective pathways based on above review.	Aug-19		Learning Disability Service Review Feb-19 included pathway review to understand the waiting time issues for specific professions/ specific needs. Revised pathways proposed and implemented. Waiting times for assessment and treatment are reviewed at monthly performance meetings.	On track	Pathways are in place which support patients being seen within agreed time standards.	Information on waiting times for interventions. Clinical pathways in place.	Aug-19		Revised pathways put in place following Learning Disability Service Review which have reduced waiting times.	On track

Overdue	2
At risk	0
On track	18
Complete-Unvalidated	9
Completed	42
Duplicate	24
Overall total number of actions:	95
Tracked number of actions:	**71**

Overdue	6
At risk	1
On track	34
Complete-Unvalidated	10
Completed	20
Duplicate	24
Overall total number of actions:	95
Tracked number of actions:	**71**