CORPORATE REPORT SUMMARY

Name of meeting:	Health Overview and Scrutiny Committee		
Date of meeting:	September 2018		
Name of report:	Livewell Southwest CQC Action Plan		
Authors:	Geoff Baines		
Approved by:		**Presented by:**	

PURPOSE OF REPORT:

To inform the committee of the action plan response to the Livewell Southwest CQC Inspection report published 7 August 2018.

RECOMMENDATION(S):

To note progress.

APPROPRIATE LIVEWELL STRATEGIC AMBITION (please tick):

✓	**Collaboration**	*Working together with system partners to achieve effective, integrated, affordable services.*
✓	**Co-ordination**	*Re-align service delivery towards a "best bed is your own bed" approach.*
✓	**Choice**	*People we care for will be supported to independently manage their own wellbeing, health and care in the way that they determine will increase their quality of life.*
✓	**Prevention**	*Support people of all ages, including our workforce, to be as fit, healthy and as independent as possible, for as long as possible.*
✓	**Community**	*Create strong networks and partnerships with a wide range of professionals and community groups so that support is responsive and provided within the person's local community.*

Please tick as appropriate:

✓	This paper provides **assurance** for the above objectives
	This paper presents **a risk** to achieving the above objective

Care Quality Commission Livewell Southwest Inspection Report

Following a well Led inspection by the Care Quality Commission (CQC) between January and May 2018, the Livewell Southwest CQC inspection report was published on 7 August 2018.

The overall rating for Livewell Southwest is 'Good' (Green) with an improvement since our last inspection published in 2016 of safe, from requires improvement to good and of caring, from good to 'Outstanding' (Blue).

It is worth noting that the rating for 'caring' in Edgecumbe, our older people mental health services, moving from good to outstanding contributed to the overall rating for Livewell moving to outstanding. This is in addition to the outstanding ratings for the Acute Mental Health services at Glenbourne and the community learning disability services. In addition since the 2016 inspection there had also been improvements in;

- 'safe' moving from requires improvement to good for Greenfields our mental health Rehabilitation service and Cotehele older persons mental health sevrice;
- 'effective' moving from requires improvement to good for the adult place of safety (also referred to as the Section 136 POS);
- 'responsive' and 'well led' moving, and as a result overall, moving from requires improvement to good for specialist community mental health services for children and young people.

A summary of the overall ratings for each of the five CQC key questions, with an arrow to highlight where our ratings were the same as in 2016 or have improved is illustrated below;

In addition to the full report it is pleasing to note the following extracts from the press release from the Care Quality Commission that accompanied the publication;

'A team of inspectors from the Care Quality Commission visited the organisation in May 2018 to check the quality of five mental health services and two community health services:

- *Child and adolescent mental health wards*
- *Wards for older people with mental health problems*
- *Mental health crisis services and health-based places of safety*
- *Specialist community mental health services for children and young people*
- *Long-stay or rehabilitation mental health wards for working age adults*
- *Community health inpatient services*
- *Community end of life care life care*

CQC also looked specifically at management and leadership to answer the key question: Is the organisation well led?

Following this inspection the organisation's rating for caring has been raised to Outstanding. The organisation is still rated as Good for being safe, effective, responsive to people's needs and well led.

The inspection does not change CQC's overall rating for the organisation, which remains Good.

Karen Bennett-Wilson, CQC's Head of Inspection for mental health in the South West said:

"Livewell Southwest CIC is providing good care to those living in Devon and Cornwall and the organisation can be proud of many of the services that it manages.

"We saw staff interacting with people who used the service and those close to them in a respectful and considerate way. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity.

"Many of the wards managed by the organisation were environments that were recovery focused and supported patients with specific needs. "

In addition to the positive inspection report and areas of outstanding practice identified above, two of our 15 core services were rated overall as requires improvement. These include Plym Bridge child and adolescent mental health ward and community end-of-life care services. As a result the inspection report has highlighted;

- 4 requirement notices that set out 9 actions that we must undertake relating to Plym Bridge and end-of-life care;
- 40 areas of practice that as an organisation we should improve.

For all of the above actions a comprehensive action plan has been developed to be overseen by the Performance sub-committee of the Livewell Southwest Board (see copy attached).

The action plan has been submitted to the CQC and as part of the routine ongoing post inspection process, a regular provider engagement meeting has been established in order to report ongoing progress and continued intelligence sharing.

In conclusion, the outcome of the CQC inspection clearly demonstrates an overall high level of performance being achieved by the organisation where particular recognition should be noted for all of the staff and teams who continue to work hard day in and day out and can be very proud of their achievements. Areas for improvement have also been highlighted and action is being taken to ensure that these issues are addressed to provide good quality services for all of our local people and their families.

Geoff Baines

Director of Patient Experience Quality and Safety

20 September 2018.

LIVEWELL SOUTHWEST CIC - ACTION PLAN SUMMARY
CQC ACTION PLAN FOLLOWING INSPECTION MAY 2018

RAG Key
Green - Action completed within required timescale
Blue - Action in line with required timescale
Amber - Action behind required timescale
Red - Action not on track of required timescale

Impact Key
S/T - Short Term - to influence and create change over 0-3 months
M/T - Medium Term - to create change in practice over 0-6 months
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CQC Recommends
M - Must do
S - Should do

Vicky Romback, Sarah Goddard and Tracy Clasby

Ref	Recommendation	Action Required	Target Start Date	Target Delivery Date	Lead	Progression on Actions 30th September 2018	RAG Rating 30th September 2018	CQC Recommends
	Child and Adolescent Mental Health Wards							
1	Action the organisation MUST take to improve							
1.1.	The provider must review its risk assessments and blanket restriction policy. This includes the blanket restrictions imposed on the young people and the non-individualised assessment of the restrictions (Regulation 12)	Matron and unit manager meeting to review blanket restrictions within the unit, and consider a unit/organisational policy. Risk assessment where those that cannot be removed to be completed, gradual phasing out of blanket restrictions. Introduction of Safewards in PBH will work towards creating a safe culture within the unit, limiting the use of blanket restrictions including the use of mobile phones and electronic devices	01/09/2018	31/03/2019	VR/SG	Vicky Romback and Amanda Williams are meeting to complete a Blanket Restrictions policy in October. We have looked at national guidance and best practice to seek advice in this area. Furthermore, at the unit we have set up a development meeting to review improvements as a staff team. So far we have removed the 'no mobile phones' and implemented access. This has led to a reduction in incidents during the evening. We are reviewing all blanket restrictions at our next development meeting in October.		M
1.2	The provider must ensure that regular team meetings take place and are recorded (Regulation 17)	Team meetings are now taking place and information for all meetings will be held on a shared drive for evidence. This will be monitored through locality meeting	01/09/2018	31/12/2018	VR/SG	Team secretary and Matron met to develop a new shared drive and team meetings schedule. Minutes will be taken for each meeting and saved in this shared drive.		M

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1.3	The provider must ensure there are robust procedures for sharing of information and learning following incidents (Regulation 17)	Weekly huddle for clinical staff to review weekly incident themes. Governance/development meeting to ensure senior oversight on a monthly basis. Also discussed at locality meetings monthly	01/09/2018	31/12/2018	VR/SG	Slight change to action in that it is now part of the monthly development meeting. VR collates data and adds to run charts. Last month we reviewed restrictive interventions data.		M
1.4	The provider must ensure supervision and appraisal of staff members happen regularly (Regulation 17)	Supervision will take place in line with LSW policy. This will be monitored monthly at performance. All staff will receive an appraisal annually which will also be monitored monthly through performance	01/09/2018	31/12/2018	VR/SG	Senior staff members have all received line management and appraisal alongside a new line management structure which ensures each staff member is tasked with carrying out LM and supervision within policy. We have also set up a number of clinical supervision groups and a nursing forum for training and education.		M
1.5	The risk register must be updated appropriately and more accurately reflect key risks (Regulation 17)	Matron to get register up to date and support the ward manager in the on-going review of current risks and addition of new risks	01/09/2018	31/12/2018	VR/SG	All new identified risks have been entered onto PBHs risk register by Matron. These are relevant to PBH. Old ones will be reviewed and amended this month. Ligature audit completed, workbook complete but needs to be moved to the electronic system.		M
1.6	The provider must ensure that fridge temperatures and checks are recorded daily (Regulation 15)	Process for robust fridge temperature checks and a process for reporting exceptions now in place and monitored by the matron	01/09/2018	31/12/2018	VR/SG	This has been highlighted to all staff. Planned checks will happen when the resus equipment is checked and process for alerting temps outside of normal range - established. There is an audit process in place to check the appropriate monitoring and recording. Spot checks will be completed by the DLM to provide assurance		M

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2	Action the Organisation SHOULD take to Improve							
2.1	The provider should ensure that cleaning schedules are adequately recorded and any gaps in the cleaning record explained on the record.	these schedules are now in place and held by the hotel services management. Any areas of concern will be raised with the matron / hotel services manager.	01/09/2018	On-going	VR/SG	Cleaning schedules are sent to mount gould monthly. These will be sent electronically to the matron for saving on the shared drive.		S
2.2	The provider should improve the risk assessment process. The risk assessments should be more specific and include a detailed description of antecedents and actions plans.	All registered staff to complete CPA training and engage in learning sessions and forums on the unit. All staff involved in risk assessment to be competent and able to assess and manage risk as part of the MDT and record this appropriately.	01/09/2018	31/12/2018	VR/SG	A nursing forum has commenced to meet with staff and develop a care planning/risk assessment and management process. The team are currently testing the recovery star model of care planning.		S
2.3	The provider should improve the young people's care plans. These should be person centred, individualised and not generic	Create person centred care plan using the recovery star model. Staff to be trained and competent in implementing this alongside the CPA process. Create audit process to review this outside of the record keeping audit.	01/09/2018	31/12/018	VR/SG	Action as above. The recovery star is a solution focused tool which includes a holistic self-assessment by the young person to demonstrate progress.		S
2.4	The provider should evidence young people's involvement in their care plans and to evidence that a young person was offered a copy of the care plan.	Embed person centred care planning as part of the above actions. Create audit process to review this outside of the record keeping audit.	01/09/2018	31/12/2018	VR/SG	As above		S
2.5	The provider should identify staff that require training in Gillick competence and provide training, as well as recording their attendance.	Training plan to identify all non-mandatory and essential training for all staff to monitor required training, attendance and out of date staff. Monitored through performance	01/09/2018	31/07/2019	VR/SG	Ward manager leading on booking in dates for MHA and gillick competence training.		S

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2.6	The provider should ensure proper medicines management. This includes the correct storage, disposal and ordering of medication.	Ensure all registered staff are up to date with medicines competencies and bitesize training sessions by pharmacy to offer CPD around medicines management. Monitored through line management	01/09/2018	31/12/2018	VR/SG	ward manager is leading on a programme for carrying out medicines assessments in line with appraisal process.		S
2.7	The provider should identify staff that require Mental Health Act training, support them to attend training and keep a record of their attendance.	Training plan to identify all non-mandatory and essential training for all staff to monitor required training, attendance and out of date staff. Monitored through performance	01/09/2018	31/08/2019	VR/SG	Training compliance data is known for all within the team and is currently being reviewed in line with the action above.		S

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CQC REGULATION
M - Must do
S - Should do
MR- Must do & Regulation

Coral Styles, Shona Cornish and Sharon King

			Target	Target				
Ref	**Recommendation**	**Action Required**	**Start Date**	**Delivery Date**	**Lead**	**Progression on actions 30th September 2018**	**RAG Rating 30th September 2018**	**CQC Recommends**
	COMMUNITY END OF LIFE							
1	Action the organistion MUST take to improve							
1.1.	The provider must ensure that the healthcare assistants have appropriate end of life training to work with patients and their families or those close to them (Regulation 18)	Team to have training and sign off of competencies where available : RAPID (complete)	09/08/2018	01/12/2018	SK / MT	complete		M
		clinical observations				Complete		
		sepsis				Complete		
		Physical signs of dying person				All booked on training completion date 02.11.2018		
		Six steps Ambition for the team but as TUPE going forward needs to be checked if this can be part of due diligence, discuss with George Lillie. CL				TUPE has been discussed with George Lillie at Westen Locality End of Life Group, initial agreement that any outstanding training will be provided		
1.2	The provider must take steps to ensure all medications administered by the service have an up to date, accurate and legible prescription to include doses, in line with the NMC standards for medication administration (Regulation 12)	Check the content of syringe driver training for Livewell and St Luke's for comparison. SK will attend both sessions and link with trainers.	09/08/2018	01/04/2019	SK/CS	SK booked to attend both sessions and link with trainers. 19.09.2018 Training good , would be better if Livewell Trainer available for whole session to answer queries about local policies. However training will change to incorporate more than the procedure, include physical signs, pharmacology and possibly VOED into a one day session. SK/ PH / NL will aim to have trail of first new session by April 2019. We are using rep for training at the moment as she brings dummy drivers for us to use, we have no drivers in the training suite,can we access drivers for training?		M
		Check what is taught in relation to medication management	09/08/2018	01/01/2019	CS	CS to attend medicines management training session and review date booked Dec 2018, there are differences in policies for inpatient and community which need to be aligned in relation to training, however all staff have acces to appropriate training		
		Look at Syringe driver competency to ensure clarity around understanding prescriptions CS	09/08/2018	01/11/2018	CS/SK	CS and SK have had initial look at syringe driver competency, it is fit for purpose currently but may need amending following review of training and policy		
		Check with Matrons what compliance with syringe driver competency is with all teams CS and SC	09/08/2018	30/09/2019	CS	Check with Matrons what compliance with syringe driver competency is with all teams, CS has sent email to all matrons asking for details of compliance of all RN's by 3rd September 2018. Minimal response from matrons so reminder sent 20/09/2018 to be returned by 30th Sept. Audits showed no areas of concern accross all teams, vast majority of staf completent and had had approproate training, some preceptees and updates outstsnding but all booked on trainning sessions.		
		Gap analysis of staff competent and ensure they all receive update if needed SK, CS, SC	09/08/2018	01/03/2019	CS/ SK/SC	Gap analysis of staff competent and ensure they all receive update if needed, this will be undertaken following response from matrons and review of training		
		New syringe driver prescription chart in final development stage (for Western Locality) awaiting sign off SK, CS	09/08/2018	TBC	SC/CS/SK	New syringe driver prescription chart in final development stage (for Western Locality) awaiting sign off SK, CS		
		Ensure communications about new chart are shared and staff understand their responsibility	09/08/2018	TBC		Ensure communications about new chart are shared and staff understand their responsibility will be undertaken when new chart published		

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1.3a	The provider must ensure the monitoring and auditing of quality and effectiveness of the community end of life service.	Look into differing measures, current popular is OACC:	09/08/2018	01/04/2019	CS SK	Look into differing measures, current popular is OACC SK CS to meet with St Lukes to see how they use OACC measures. CS and SK met with GW, there are some aspects of OACC that we could use but will look at hoe this		
		Ask NEW Devon CCG STP if there is a preference and any wish for consistency CS	09/08/2018	30/10/2019	CS	Ask NEW Devon CCG STP if there is a preference and any wish for consistency, CS has emailed CCG to add to agenda in October		
		Ask St Luke's education team if they have any other information SK	09/08/2018	30/09/2018	SK	Ask St Luke's education team if they have any other information		
		Talk to BI about how we can use the Bundle to pull out information	09/08/2018	30/12/2018	SK/CS/SC	Talk to BI about how we can use the Bundle to pull out information Contact made with BI, meeting arranged to look through End of Life Bundle. Meeting 19/09/2018 nd agreements made around eol bundle, incidents and complaints. Awaiting draft of revised bundle we will then trail data capture		
1.3b	Improve measures of patient outcomes specific to specialist end of life care (Regulation 17) (note we do not provide specialist palliative care)	Ask Claire Gatehouse if there is a way of pulling information on palliative and end of life care form patient experience tool for all teams, or do we need to have add on section? SK	09/08/2018	01/12/2018	SK/CS	Ask Claire Gatehouse if there is a way of pulling information on palliative and end of life care form patient experience tool for all teams, or do we need to have add on section? Meeting arranged for September to look at tool. Meeting and draft audit tool agreed, Once we have SK will ask for feedback		M
		Ask Sarah Jones if there is a way of pulling end of life information from incidents, if not can we make a way of allowing staff to do so? SK	09/08/2018	01/12/2018	SK/CS	Ask Sarah Jones if there is a way of pulling end of life information from incidents, if not can we make a way of allowing staff to do so? email send to Sarah, awaiting response when she returns from leave. 19/09/2018 Discussion with SJ, draft to be made by SJ for approval. This is now available on the incident reporting system.		
		Ask Dawn Wallbridge if there is a way of pulling information from complaints and concerns, if not, is there a way to do so? SK	09/08/2018	01/12/2018	SK/CS	Ask Dawn Wallbridge if there is a way of pulling information from complaints and concerns, if not, is there a way to do so? email to Dawn awaiting response when she returns from leave. 20/09/2018SK met with Dawn, date same as incidents so same catagorisations to be used		
2	Action the Organisation SHOULD take to Improve							
2.1	Take significant steps to improve staff attendance in mental capacity act and deprivation of liberty safeguards and ensure that the reporting template captures this information.	To confirm with the trainiing department	09/08/2018	09/10/2018	CS	The training department have now confirmed that there is updated education session for both MCA and DoLs in mandatory training and this can be monitored through ESR		S
2.2	Improve the standard of records for do not attempt resuscitation and treatment escalation plans.	Ask Andy Field if there could be more on what good TEP looks like on Resuscitation training CS	09/08/2018	01/04/2019	CS SK	Ask Andy Field if there could be more on what good TEP looks like on Resuscitation training, discussion with Andy, information to be included in all resuscitation training agreed,		S
		TEP Audit for community services within 2018-2019 action plan of Western Locality Group	09/08/2018	01/04/2019	CS	Audit within 2018-2019 action plan of Western Locality Group.		
		Meeting with Medical Director to discuss how to link and improve within Livewell Medical Teams CS, SK	09/08/2018	31/11/2018	CS SK	Audit tool and date of audit TBC, meeting in October so will calrify then awaiting date to meet Sam Roy arranging		
		Highlight to Primary Care Board MT	09/08/2018	30/09/2018	MT	MT has spoken to Western Primary Care Board.		
		Information to all staff via comms about what is expected	09/08/2018	15/12/2018	SK/CS/SC	Information to all staff via comms about what is expected date for End of Life wek to be agreed, possible date in Novemebr		
		Have a designated week within Livewell dedicated to Palliative and End of Life Care to inform and engage with staff	09/08/2018	31/03/2019	MT/SK/CS/SC	Have a designated week within Livewell dedicated to Palliative and End of Life Care to inform and engage with staff, contatc with comms team made but yet to agree a date		
2.3	The staff understanding of the vision and values and how they fit with the end of life strategy.	Have a designated week within Livewell dedicated to Palliative and End f Life Care to inform and engage with staff	23/08/2018	31/03/2019	MT CS SK SC	S has contacted comms to ask for support and advise as to best way, Forum will support this, review of strategy at next leads meeting.		S
		Relook at Strategy to ensure meets our needs	09/08/2018	31/03/2019	MT CS SK SC	CS to send strategy to all to read before op group meeting in Oct		
2.4	The standard of the corporate risk register and addition of recognised and relevant risks.	Add to risk register, MT to own as a corporate risk MT	23.08.18	31.10.18	MT	complete		S

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2.5	The District Nursing day team to provide a handover to the Out of Hour's District Nursing team.	effectiove hand over to be implemented	23.8.18	12.10.18	Shona Cornish Dn service	23.8.18 Sc to meeting with Out of Hours manager to establish current process and review. Set action plan and implementation schedule to support effective referral/active update list process.in line with 24 hour service.		S
2.6	Register to take part in the National Audit of Care at End of Life ("NACEL")	Register with the audit and ensure we undertake audit within current year	23.8.18	01/07/2019	SK TC	Registered audit, Trish Cooper and SK will lead will be completed within timescale set for the audit TBC, need some support from BI completion due in October		S
		Forum to lead on this so good and not so good practice can be shared	23.8.18		SK TC	SK now leading but will share results with forum		
2.7	Re-establish multi-disciplinary team meetings in the District Nursing service.	this will either be in line with the Gold Standard Framework or the Locality MDTs as appropriate.	23.8.18	31.10.18	SK CS MT SC	will be discussed and agreed at next leads meeting 19/09/2018		S

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Sandra Pinch James Glanville and Tracy Clasby

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	Long Stay or Rehabilitation Mental Health Wards for Working Age Adults							
1	Action the Organisation SHOULD take to Improve							
1.1.	The provider should provide adapted bathroom or toilet facility for people with disabilities and impaired mobility	1. Aids and adaptations will be considered as part of any assessment for Greenfields. 2. Referrals for Syrena will be considered on an individual basis and aids and adaptations are undertaken in line with OT and physio assessment to meet individual needs. 3. Consideration could be given to ramps to access Syrena's downstairs shower. 4. formal referal to NHSPS to review disabled access to showers	20/08/2018	31/10/2018	Amanda Cooper/Diane Bratt	1. Bathrooms have been reviewed by estates on 12/9/18 to consider options that could improve options for adaptations. A room has been identified on Greenfields that could be converted into fully DDA compliant bathroom. 2. Anti-ligature works have now installed shower seats in bathrooms in Greenfields 3. Syrena bathroom options are more limited and the building not considered to be DDA compliant and at the current time will be reviewed on a case by case basis. 4. Discussion to be taken regarding capital funding if work is to be progressed.		S
1.2	The provider should record staff supervision in line with the organisations policy	1. Have a robust recording and checking system to ensure that line management supervision is carried out consistently every three months	20/08/2018	30/09/2018	Amanda Cooper/Diane Bratt	The Manager at The Greenfields Unit and Syrena House have devised a System to ensure that staff identified as requiring supervision that month is clearly identified. This allows for a robust checking system to ensure that staff record and check frequency of supervision.		S
1.3	The provider should provide staff training in the Mental Health Capacity Act in line with the provider's guidance and promote staff's understanding of their role in assessing patient's mental capacity.	1. Staff will be booked to attend MCA training in line with availability through Professional Training and Development 2. Further awareness sessions will be booked with MCA Lead for Syrena House staff to promote staff's understanding 3. Circulation of Mental Capacity Act including DOL's Policy to Syrena Staff and discussion at staff meeting	20/08/2018	31/12/2018	Amanda Cooper/Diane Bratt	1. Ian Stevenson was booked to undertake a session at Syrena House on 19th and 25th September and 2nd October. 55% now in date, Manager to arrange further dates with Ian.		S
1.4	The provider should ensure that staff carry out risk assessments such as STORM assessment for all patients with high risk of self-harm and suicide risk in line with the organisations policy	1. Registered staff will be booked to attend 2 day newly revised CPA training which will include management of self harm and suicide.	20/08/2018	31/12/2018	Amanda Cooper/Diane Bratt	1. All Greenfields registered staff have been booked to attend 2 days training and this will be complete by 12th December 2018. (1 need to book due to absence). 2. Syrena staff are being booked onto the 2 day training programme. To date 3 people are booked to attend.		S
1.5	The provider should ensure that care plans are written in a consistent style for all patients in line with provider's policy	1. Adopt caseload Reviews for Line Managers to ensure that record keeping will be monitored and feedback can be provided to staff. This will take place every 6-8 weeks with registered staff. This will be recorded on SystmOne.	20/08/2018	30/10/2018	Amanda Cooper and Diane Bratt	1.Syrena, new deputy in post, line management structure has been reviewed, caseload reviews will start at the next booked line management. 2. Plan to implement for staff members as part of ongoing supervision when next due. 3. Prompt template agreed to support review of records		S
1.6	The provider should ensure the risk assessments are written in a consistent way to capture risk of patient to self, to others and from others	1. Adopt caseload Reviews for Line Managers to ensure that record keeping will be monitored and feedback can be provided to staff. This will take place every 6-8 weeks with registered staff. This will be recorded on SystmOne.	20/08/2018	30/10/2018	Amanda Cooper and Diane Bratt	1. Syrena, new deputy in post, line management structure has been reviewed, caseload reviews will start at the next booked line management. 2. Plan to implement for staff members as part of ongoing supervision when next due. 3. Prompt template agreed to support review of records		S

1.7	The provider should ensure that staff follow the self-administration of medication policy consistently	1. Give verbal, email and written advice (copy of policy) regarding the correct process for recording of self-administration of self-medication 2. Medication charts will be audited to monitor compliance and consistent recording in line with The Self Administration of Medication policy 3. Visual aid will be provided to aid improved recording	20/08/2018	31/10/2018	Amanda Cooper/Diane Bratt	1. Staff have been given verbal and written advice regarding the correct process for recording of self-administration of self-medication 2. In both units medication charts are audited on a weekly basis for omissions but it has been recognised that consistency in recording needs continual monitoring.		S
1.8	The provider should ensure that work to remove ligature points are carried out in line with the action plan to address and mitigate ligature risks	1.Ligature works to be complete in line with scope of works within the next five weeks 2. A ligature re-audit will be undertaken on completion of works 3. Outstanding works will be mitigated and regularly reviewed as part of risk register or as part of individual care planning	20/08/2018	31/10/2018	Sandra Pinch Amanda Cooper Diane Bratt Suzann Adams Nathan Carr	1. Modern Matron and Ward Managers met with Project manager Ray Clark to review works to date and compile a list of oustanding work in line with scope of works. 2. LSW property manager is liaising with contractors to monitor progress. Some delays in the work have slowed progress and timescales for completion being reviewed . LSW Anti-lig meeting chaired by risk manager scheduled for 31.10.18		S

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Lisa Gimingham, Vicky Romback and Tracy Clasby

Ref	Recommendation	Action Required	Target Start Date	Target Delivery Date	Lead	Progression on Actions 30th September 2018	RAG Rating 30th September 2018	CQC Recommends
	MENTAL HEALTH CRISIS SERVICES AND HEALTH BASED PLACES OF SAFETY							
1	Action the Organisation SHOULD take to Improve							
1.1.	The provider should ensure that staff in the Home Treatment Team are clear on the vision of the service and the future of the organisation, as much as possible.	Staff briefing is scheduled with DLM to update team on the change in direction for crisis mental health provision. HTT manager to discuss in team business meeting as well	08/08/2018	31/09/2018	Lisa Gimingham and Philippa Cook	DLM attended team meeting Sept 18. Also emaill communication with all staff 10.9.18		S
1.2	The provider should ensure patients are involved in the creation of their care plan	all care plans will include engagement with patients created jointly	08/08/2018	30/09/2018	Philippa Cook and Katherine Chattaway	Caseload supervision to be used to discuss this and check for quality. This continues via line management and caseload supervision. Will continue to monitor progress in this area		S
1.3	the provider should ensure discussion around risks are structured and recorded appropriately	The Clinical review template is being changed to include a clear prompt to discuss risk. Risk management meetings will have an agenda	08/08/2019	30/09/2018	Philippa Cook and Katherine Chattaway	Caseload supervision to be used to discuss this and check for quality. MDT format changed as of 14th sept . Progress monitored via via line management and caseload supervision. Review		S
1.4	The provider should ensure risks are consistently translated to care plans	The content and quality of care plans will be reviewed by the HTT practice lead. Caseload supervision will be used to support staff to do this. The team will be reminded in the business meeting	08/08/2018	30/09/2018	Philippa Cook and Katherine Chattaway	Caseload supervision to be used to discuss this and check for quality. Discussed regulalrly in team meetings. On-going monitoring via caselaod management. Review date end of Oct 18		S
1.5	The provider should ensure external stakeholders are clear on the function of the Home Treatment Team	Leaflets and webpage content to be reviewed and updated to ensure the purpose of the team is clear	08/08/2018	30/09/2018	Philippa Cook and Katherine Chattaway	Leaflets have been updated being sent to key extenal stakeholder. Request for updated web page made via comms.		S
1.6	The provider should ensure the Home Treatment Team has a system to monitor and log safeguarding activity	the team will record all safeguarding activity	08/08/2018	30/09/2018	Philippa Cook and Katherine Chattaway	Now in place		S

LIVEWELL SOUTHWEST CIC - ACTION PLAN SUMMARY
CQC ACTION PLAN FOLLOWING INSPECTION MAY 2018

RAG Key
Green - Action completed within required timescale
Blue - Action in line with required timescale
Amber - Action behind required timescale
Red - Action not on track of required timescale

Impact Key
S/T - Short Term - to influence and create change over 0-3 months
M/T - Medium Term - to create change in practice over 0-6 months
L/T - Long Term - will take time to bed in and create required change and long term sustainability

CQC Recommends
M - Must do
S - Should do

Jayne Blood, Sarah Goddard and Tracy Clasby

Ref	Recommendation	Action Required	Target	Target	Lead	Progression on Actions 30th September 2018	RAG Rating 30th September 2018	CQC Recommends
	SPECIALIST COMMUNITY MENTAL HEALTH SERVICES FOR CHILDREN AND YOUNG PEOPLE							
1	Action the Organistion SHOULD take to Improve							
1.1.	The provider should ensure the managers monitor the number of safeguarding referrals to the local authority	The number of safeguarding referrals to the LA need to recorded and monitored	06/08/2018	Aug-18	Jayne Bood	A child safeguarding referral box to be added to the "Child Welfare" tab and template on Systmone. This is now in place and is to be completed when a safeguarding referral is made to Children Social Care. This will enable you to capture the referral data for our service and report whenever need.		S
1.2	The provider should ensure that all young people receive a copy of their care plan	Evidence that all CYP and families are given a copy of their care plan.	06/08/2018	01/10/2018	Jayne Blood	The Caseload managers are discussing care plans during each caseload management meeting. The staff member will record on system one if the young person accepted a copy or their care plan or refused to take a copy with them. We have found that some CYP do refuse if this is also record in the tab journal so the manager can review and quality assurance this process. As we move forward with our IT development we will be able to electronically send Care plans which will help with the young people that do not like hard copies of their care plans.		S

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S - Should do

Mandy Rolf, James Glanville and Tracy Clasby

Ref	Recommendation	Action Required	Target Start Date	Target Delivery Date	Lead	Progression on Actions 30th September 2018	RAG Rating 30th September 2018	CQC Recommends
	WARDS FOR OLDER PEOPLE WITH MENTAL HEALTH PROBLEMS							
1	Action the Organisation SHOULD take to Improve							
1.1.	The Provider should ensure that all staff complete Mental Health Act training	Mental Health Act Training has commenced for all staff on Edgcumbe & Cotehele. This is recorded within staff personnel files & on ESR	01.05.18	01.12.18	Ward Managers & Matron	Training on the Mental Health Act has commenced for all staff. Currently,18 staff on Edgcumbe and 20 staff on Cotehele have completed training sessions with the MHA Manager.All remaining staff are are booked for sessions into 2019		S
1.2	The provider should ensure that staff write the 'opened date' on all liquid medication after opening, in line with the provider's policy	All bottles of medication have the 'opened date' recorded at the time of first use	17.04.18	17.04.18	Ward staff	This action was implemented on the day of inspection and has been maintained. Staff informed via their meetings with Ward Manager and spot checked by Matron		S

1.3	The provider should record staff supervision in line with the organisations policy	All staff have been reminded of the requirement to receive Supervision three monthly. New method of recording has been introduced. Edgumbe & Cotehele staff are now undertaking Practice supervision	01.05.18	01.12.18	Ward Managers, Matron & MHA Office Trainers	Staff on both Edgcumbe and Cotehele have commenced supervision. Edgcumbe have also received support from Psychology for staff. Group supervision has also been implemented on Cotehele for all staff. Staff are being encouraged to continue with this and ESR is now set up to record information.		S
1.4	The provider should ensure that learning from incidents is recorded and disseminated to all staff	Incidents are discussed at Unit level for internal incidents and discussed at team meetings and handovers. Learning is also completed through the locality meeting	01.06.18	01.12.18	All staff	Staff on both Edgcumbe and Cotehele have received feedback regarding concerns and complaints via their monthly Ward Business meetings. This is now a standing agenda item for both Units. A planned awayday for Cotehele in December will be based around two complaints over the past two years		S

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Sharon Scoging and Sarah Pearce

Ref	Recommendation	Action Required	Target Start Date	Target Delivery Date	Lead	Progression on Actions 30th September 2018	RAG Rating 30th September 2018	CQC Recommends
	COMMUNITY HEALTH INPATIENT SERVICES							
1	Action the Organisation SHOULD take to Improve							
1.1.	The provider should ensure prompt action is consistently taken when potential safeguarding concerns are identified	Registered managers to check all staff are booked onto children's and adult safeguarding training updates and monitored through performance meetings	01/09/2018	01/12/2018	Sarah Pearce Sharon Scoging	28/9/18 LCC, Plym and Stroke - Achieved compliance level for training -5 people left to book onto training across the wards, reminders sent.		S
1.2	The provider should ensure that staff consistently report incidents promptly	Refresher incident reporting training sessions to be held on all community inpatient wards	01/09/2018	01/11/2018	Sarah Pearce Sharon Scoging	28/9/18 LCC, Plym and Stroke - Incident reporting training sessions held on the 10th and 12th Sep on the units with attendance from 50		S
1.3	The provider should ensure that individualised and specific information is consistently recorded within the patient medial records. The information should direct and inform staff of the action they are required to take to meet the assessed care and treatment needs for each patient. This should include full guidance on specific equipment being used. Patient monitoring documents should be completed in full	Registered Managers to work with records manager to review record keeping audit to ensure all "should do" actions are within the audit. Record Keeping Audit to be completed on all community in-patient areas	20/08/2018	31/12/2018	Sarah Pearce Sharon Scoging Claire Batten	28/9/18 - chasing email sent to corporate Information Governance manager		S
1.4	The provider should review the storage arrangements on the community hospital wards to ensure that patients, staff and visitors to the hospital have clear access to all areas.	Registered managers to review infection prevention and control audits to ascertain if storage is suitable and what improvements are recommended. RMs to remind all staff to store equipment to give access to patients, staff and visitors.	01/09/2018	30/09/2018	Sarah Pearce Sharon Scoging	28/9/18 - LCC, Stroke and Plym. No infection control issues identified around storage. Ward storage issues are not easily resolved as there is limited storage, however Ward staff reminded to keep access/throughways clear. Action completed within the limitations of the units.		S
1.5	The provider should ensure that medicines are consistently stored securely at all times	Registered Managers to review medicines storage audits. Matrons to carry out spot checks on storage of medicines in units.	01/09/2018	30/09/2018	Sarah Pearce Sharon Scoging Ward matrons	28/9/18 - request for updates to matrons.		S
1.6	The provider should ensure that appropriate arrangements are consistently made for patients whose first language is not English to access translation and interpretation services	Information and posters to be available in all community in-patient settings to inform of translation and interpretation services.	20/08/2018	31/08/2018	Sarah Pearce Sharon Scoging	Action completed. All units reminded of the policy and sent to share with staff.		S