Theme	Mazars Recommendations	SHFT Actions	Responsible Lead	Divisional Responsible Lead	Executive Accountability	Process Completion Date	Process Status	Process Progress Evidence	Evidence of Outcome Achieved	Measuring Success Date	Recovery Date	Outcome Status	Progress Update	Outcome Measure
Thematic reviews	11. The Trust should provide staff with regular training and guidance to help them manage physical health conditions of long-term mental health service users. Diabetes management stands out as an area for greater awareness from a number of cases we reviewed.	11.1a Review the content of the five day physical health course which LEaD provide. Course content and learning outcomes which will be reviewed. 11.1b Ensure that there is the correct percentages of staff attending from each service. 11.1c Attendance data recorded per service. 11.1d Review of the published Physical Assessment and Monitoring Policy and Procedure for Mental Health and Learning Disability Services which includes a reference to diabetic monitoring. 11.1e The physical health monitoring policy will be reissued to all clinical staff within the Adult Mental Health division (AMH), Learning Disabilities (LD) and Older Persons Mental Health (OPMH)	Bobby Moth, Associate Director of LEaD Steve Coopey, Head of Clinical Development (11.1a, 11.1b and 11.1c) Simon Johnson, Head of Essential Delivery (11.1d and 11.1e)	Carol Adcock, Associate Director of Nursing AMH (11.1a, 11.1b & 11.1c) Mary Kloer, Clinical Services Director AMH (11.1a, 11.1b & 11.1c) Kate Brooker, Associate Director AMH (11.1a, 11.1b, 11.1c, &11.1d) John Stagg, Associate Director of Nursing LD (11.1a, 11.1b & 11.1c)	Mark Morgan, Director of Operations AMH, LD & TQ21 Sara Courtney, Acting Chief Nurse (11.1a, 11.1b & 11.1c - joint accountability)	31.07.16	Complete	Evidence required: Course content and learning outcomes (11.1a) Percentages of for the staff who have undertaken it by service (11.1b) Attendance registers (11.1c)	Divisional and service level training records to that staff have been trained. (11.1b & 11.1c) Achieve of 90% compliance to clinical audit of physical health needs. (11.1a) Physical health audit to be undertaken in Q3. Audit of SI contributory factors to be undertaken in Q2. (11.1a)	30.11.16	30.06.2017 revised recovery date 31.10.17	Overdue	11.1a Course content reviewed by the ADoNs from AMH and LEaD. Additional options being scoped alongside the 5 day course. Alternatives are physical health specialist subject sessions and e learning. Subject matter inclusive of diabetes and respiratory. 11.1b & c Training records being obtained by L Hartland LEaD. 04.08.16 Input evidence request made for information - meeting was held with ADoNs to discuss e learning and shorter course options October 2016: 5 day physical health course reviewed. The duration of the course does not make it a feasible option for inpatient staff. AMH, Specialised Services & LD Plan - Agreed all qualified nurses and HCSW's working in inpatient services will need to demonstrate competency in the following: - Physical Observations, - Track and Trigger Tool and SBAR(d), - Blood Glucose Monitoring . LEaD practice educators will assess the competency of senior nurses. Nurses achieving level 4 competency will then cascade assessments. LEaD will be introducing 3 skill buttons for the competencies on the training accounts of all staff in the target group on 25/10/16. Staff will be required to e-verify via the LEaD system when they have achieved each competency. All verifications will require manager authorisation. Target is for 80% of staff to be deemed competent in Track and Trigger and SBAR(d) by end of December 2016. Training/education is available via face to face or electronic delivery to support staff to acquire the knowledge and skills in physical health assessment and monitoring. LH meeting Kathy Jackson, Head of Nursing Inpatients (OPMH) 25/10/16. KJ is aware of this action. LH will present plan (as per action 11 above) to the ward managers at the meeting and arrange roll out of assessments for senior nurses. 11/10/16 A summary recovery plan was submitted by Steve Coopey for all actions: - 11.1a Discussions held with divisional leads to agree actions and attendance at physical health steering group commenced. Carole Adcock completed the review of 5 day physical health course. Divisional leads to agree actions following review, share work drafted on education pathway for registered staff and to confirm use of core physical health training workbook which supports competency assessment in practice. - 11.1b To agree which staff require core + additional training a nd confirm % targets trained in physical observations for mental health inpatients by 31.12.16 - 11.1c Louise to provide on-going attendance data on request or in line with agreed targets 17.10.16 11.a The risk related to physical health training in the MH inpatient units has been added to the divisional risk register (for MH) following discussion at AMH MOM in October 2016. Risk no.1100 - AMH - management of physical health care of service users. Risk states that currently the 5 day course is not attended and is being replaced with other training options. 20.10.16 11.1a Specialised Services have devised a project called improving access to physical health for the forensic patient; course developed - trainee advanced nurse practitioner masters pathway. 03.11.16 Further update re OPMH physical health course (CUSP) rolled out. 05.01.17 Update on 11.1d - Physical health assessment and monitoring policy now updated and circulated to the Resuscitation Committee for comments due back by 06.01.17. Task and finish group to be formed once the policy is agreed. A physical health strategy for AMH has also been drafted to ensure staff recognise and respond to patients' physical health needs, and work with service users in the community and look to reduce the incidence of premature mortality. Further update to be received from physical health task and finish group which will convene on	Evidence required: Course attendance records - site / service percentage (11.1b & 11.1c) - Saved 20feb17 data - T&T 87%, Phys obs 84%, Blood Gluc 81% March 2017 agreed that target training figure should be 90% trained. Results of the physical health audit of AMH sites (11.1a) 11.1a. physical health clinical audit report - MH (nov16). 11.1a nov16 audit results 93% - Helen Alger - full physical health review completed within 7 days of admission Audit of SI reports proving a reduction in physical health contributory factors (11.1a) Review of the published Physical Assessment and Monitoring Policy and Procedure for Mental Health and Learning Disability Services which includes a reference to diabetic monitoring (11.1d) AMH Physical Health Strategy (11.1d) Nov16 draft already saved. 11.1 Physical Health Report LD v0.2 11.1 Physical Health Report AMH v0.2 11.1 Physical Health Report SS (2) v0.2 11.1 TEC CQUIN update Report 26.07.2017 V6 11.1a-1 Physical health 5 day course reviewv3 11.1a-2 Mapping of deteriorating patient coursesv4
Timeliness of Investigations	16. Reporting to StEIS should be undertaken within the 2 working days of notification as required by the national guidance.	16.1a Serious Incidents will be recorded on StEIS within 2 working days of the occurrence being reported on the Safeguard Ulysses system as specified by the National Framework by the SI and Incident Team. 16.1b The 48 hr panels at Divisional Level will decided on the level of investigation required to support the prompt reporting and this will be documented on the Safeguard Ulysses system.	Kay Wilkinson, SI and Incident Manager Mandy Rogers, SI Officer Sam Clark, SI Officer (16.1a - joint responsibility)	David Kingdon, Clinical Services Director AMH Mayura Deshpande, Clinical Services Director, Specialised Services Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) Rachel Anderson, Clinical Services Director (West ISD) Juanita Pascal, Clinical Services Director (North ISD) Jennifer Dolman, Clinical Services Director (LD & TQ21) Liz Taylor, Associate Director of Nursing, Childrens and Families (16.1b - responsible for their Division)	Sara Courtney, Acting Chief Nurse (16.1a) Mark Morgan, Director of Operations AMH, LD & TQ21 Gethin Hughes, (16.1b) Director of ISDs OMPH In Patients and Childrens and Families (16.1b)	30.06.16	Complete	Evidence obtained: Serious Incident Management Policies and Procedures rewritten (16.1a) Dashboard monitoring reporting to StEIS within 48 hrs (16.1a) 48 hour panel process (16.1b)	Timescale calculation - percentage of SI's reported on to StEIS within 48 hrs of reporting to be presented as a Key Performance Indicator on the dashboard. Please note that the timescale for measuring success is: (16.1a) 31.03.16 (16.1b) 30.06.16	31.03.16 30.06.16	30.06.17 revised to 31.10.17 revised to 31.12.17	Overdue	March 2017 : 16.1a Compliance to 48 hour reporting onto StEIS: 36% (Jul-16), 19% (Aug), 42% (Sep), 59% (Oct), 75% (Nov), 44% (Dec), 65% (Jan-17) 71% (Feb) 16.1b Compliance to 48 hour panels being held within 48 hours: 55% (Jul-16), 36% (Aug), 46% (Sep), 64% (Oct), 77% (INov) 67% (Dec) 78% (Jan) 71% (Feb-17) Levels of compliance with the mortality panels being held within 48 hours is monitored through Tableau on a daily basis and this is actively discussed at the MF. The compliance to the requirement to report onto StEIS within 48 hours is monitored on a monthly basis and whilst improvement has been seen in the pressure ulcers, compliance to other serious incidents has deteriorated. It is recommended that this action remains red until indicators have reached the required trajectory. Further discussed at QIP Delivery Group the need for divisions to telephone the central SI team at end of 48 hour panel so can put any SI onto STEIS within deadline. Need to continue to monitor. A recovery date for this action has been set for June 2017. 27.04.17 16.1a Compliance to 48 hour reporting onto StEIS: 36% (Jul-16), 19% (Aug), 42% (Sep), 59% (Oct), 75% (Nov), 44% (Dec), 65% (Jan-17) 71% (Feb) 36% (Mar) 16.1b Compliance to 48 hour panels being held within 48 hours: 55% (Jul-16), 36% (Aug), 46% (Sep), 64% (Oct), 77% (INov) 67% (Dec) 78% (Jan) 71% (Feb-17) 82% (Mar) 48 hour panel guidance for ISD been amended to highlight that panel needs to call central SI team if decided that incident is SI. Performance discussed at QIPDG on 25.04.17 with ISD flowcharts/guidance shared for MH division to use if helpful. 5.5.17 Chased for status - Kay and Divisional leads / Requested summary recovery plan - Liz Taylor 8/5/17. We have not breached this in children and Families and are within compliance for reporting - updated divisional leads AMH was Mary Kloer - now David Kingdon, ISD Was Peter Hockey now Rachel Anderson. 25/5/17 evidence review panel - target not met. A change in process has occurred with SI team attending/linking into 48 hour divisional panels to get immediate update re decision making re whether incident is SI. 5/7/17. Target not met. May 17 - 75%(12/16), June 17 - 83%(10/12) 31.7.17 evidence review panel - 16.1a discussed different interpretation of SI Framework with this action using the date the incident is reported as the date for recording onto StEIS whereas commissioners /other trusts use the date the decision is made that an incident is an SI. These differences been discussed at QOC but no agreement to change. New national SI framework may make this reporting clearer - framework delayed. Niche will complete their second phase assurance and present report to QSC Sept and Board Oct so their feedback will guide completion of this action. Recovery plan to be completed and to continue to monitor until Oct 2017. 16.1b complete. 14.8.17 Target not met - 73% (11/14) SI reported onto StEIS within 48 hours. 29.8.17 evidence review panel - target not met in July (73%). Agreed to add another line to SI KPI dashboard which will report on numbers of SIs uploaded to StEIS within 48 hours of incident	Evidence required: 95% compliance to reporting to StEIS within 48 hrs - dashboard (16.1a) Compliance to 48 hr panels being held within 48 hrs (16.1b) 16.1a Number and Percentage of SIs reported onto STEIS within 48 hours 16.1a Sept17 - Mazars Action Plan KPIs Dashboard Comprehensive