SMART action plan toolkit
(For the progression of actions at Integrated Governance Group)

1. INTRODUCTION

The purpose of this document is to outline the benefits of using the SMART local action plan and to provide some instruction on how to use it.

The benefits of the SMART action plan are:

- It provides a template for developing specific actions that will produce deliverable actions in a timely way in order to deliver what needs to be achieved.
- It makes accountability of the action plan and monitoring responsibilities clear by naming the owner of the action plan, the implementation group and the date and group of the next review.
- It supports management of version control by including the date and version number.
- Provides an at-a-glance overview of the status of each action with the use of Green-Blue-Amber-Red status tracking

The action plan utilises smart principles to ensure the right information is included on the action plan.

- **S**pecific
- **M**easurable
- **A**chievable
- **R**ealistic
- **T**ime bound

2. METHOD

The relevant SMART principles are listed for each column on the action plan.

Recommendation identified (Specific):
This is the reason why the action exists. It is the issue needing to be fixed with the action(s).

Recommendations may come from varied sources including:

- 20 day executive summary reports
- Reviews of incidents and 72hr reports
- CQC reports or action notices
- Complaint investigations
- Audits
- Reports to Prevent Future Deaths (PFDs) – formerly known as rule 43 reports
- Local or Corporate Risk Registers

(This is not an exhaustive list)

It is important to be specific so it is easier to make the action relevant to the recommendation. There will often be more than one action for the recommendation.

Outcome (Measurable)
This is a measure of success. It is how to know that the actions have resolved the issues identified in the recommendation. It's important to make the monitoring measureable so it is easy to judge whether this is the case.

Actions (Specific & Achievable)
These are the items that people are going to complete. These should be as specific as possible so those who are completing the actions know exactly what they are doing. It's important that they are achievable and are designed to achieve the outcome above.

If resource implications make actions less achievable, then the constraints can be noted in the next section. If an action is identified that is out of one's control or needing corporate attention and directly impacts on unit objectives, then this should be noted on the local risk register.

Resource Demands/ Constraints (Realistic)
It is necessary to be realistic about any barriers there are in achieving the action. This section should note any issues and factor these in when agreeing timescales.

If there are no constraints, then enter 'no issues' into this section.

The Person Responsible (Realistic)
The person identified for completing each action. Ensure the person has the skills, knowledge and support to complete the task.

The Person Accountable (Realistic)
The person identified to monitor progress and ensure that an action is completed by the 'person responsible'.

Target date for completion (Time bound)
This will note the deadline when the action is to be completed by. Ongoing review will demand progress to the action and any resource demands should be revisited.

Any delays should be noted. If excessive delays to an action are noted, then escalation of the action on the local risk register should be considered.

RAG scoring
The final section is the RAG scoring. Regular review of the action plan is essential to ensure actions are progressing. Note the date of the last update and the date of the next review in the relevant boxes. Make sure review of the action plan is added as an agenda item.

Each action should be given a status update using the Green-Amber-Red scale below:

Green	**Green**	Achieved
Green	**Amber**	Work is in progress in line with target date
Amber	**Amber**	Initial work has commenced appropriate to target date
Amber	**Red**	Minimal or no work has commenced in this area due to the long lead time
Red	**Red**	Actions have not been achieved by the target date
Grey	**Grey**	Responsibility reallocated

Has the recommendation been escalated to the Local Risk Register
If any of the actions listed to comply with the recommendation/objective fail, then the recommendation will be escalated to the Local Risk Register. The risk register will assess the risk of

not being able to achieve the recommendation. Local Risk Registers are accessible to Executive Management Board, Operational Director and the Head of Compliance. This section should be used to note that it has been escalated and the reason for the action failing.

List of Evidence/ Controls
As actions are completed, the person responsible will produce documented evidence that the action has been completed and change has been embedded into practice. Documents should be listed and embedded into this section. The evidence listed will also show the controls or assurances in place to support the recommendation. If the recommendation is escalated onto the Local Risk Register, the list of evidence should be noted as current controls within the risk register.

WATERLOO MANOR: COMPLIANCE ACTION PLAN –			Date Created:
Action Plan Owner:	Mr David Ramage, Hospital Director, 01132876660	Date last updated: 14/01/16 (and version No.) V5	July 29th 2015. V4
Integrated Governance meeting Date:	18th December 2015	Next review due by – 25/01/16 Group date:	Date of next IG meeting

Recommendation Identified (in Report/Review/CQC) Issue/ Driver/ Gap/ Objective requiring action and attention (	Outcome Measure of success. How will you know the actions have resolved the issues identified in the recommendation (a set target, percentage gain, audit results etc.)	Actions Stated clearly and concisely the actions to achieve the desired outcome.	Resource demand/ constraints Relevant to all people, any issues in completion	Person Responsible Initials	Person Accountable Initials	Target Date for Completion Realistic deadline	RAG Rating Status/ See Key	
Specific	Measurable	Specific and Achievable	Realistic			Time bound		
CQC, in February 2015 identified that patients' physical health needs were not sufficiently assessed. **To explore further options with the view to appoint a GP for weekly surgery.** **Input from dietitian.**	Hospital Director and Clinical Managers identify and monitor actions through Integrated Governance Meetings to ensure that patient's physical needs are sufficiently assessed and appropriate support provided. All patients will have access to primary health care services as required. Where appropriate patients will have access to dietary advice and guidance from a qualified dietitian.	Ged McCann to explore options with local CCG's for GP input into WMH. (See below)	External factors currently influencing completion.	Ged McCann	David Ramage	31/01/2016		
		Feedback from Ged McCann. Cygnet have provided a report to DH on the provision of primary care in mental health settings. A response is anticipated from DH which may outline how such services are procured.	As above. National response expected from report to DH.					
		Dietitian now contracted to provide weekly input to patients who require this support. BMI monitored and St Andrews Nutrition Screening assessment tool used. Weight loss programmes commenced.	Minimum of monthly meetings between the dietitian and head chef.			Weekly review by dietitian		
		At least one fitness related exercise is provided by the occupational therapy team per day. Walking, gym and swimming groups available to patients. Different				In place		

		levels of ability and fitness accommodated. Up to 15 patients access these groups weekly.						
		Aqua-zumba attended regularly with OT staff and on-site/off-site gyms available and regularly used.				In place		
		Annual physical health checks provided by GP service. Minimum weekly Bp, pulse, temp and weight where patients agree. More frequently if clinically indicated.				In place		
		Antipsychotic medication monitoring tool used by RCs to monitor patient blood levels and ecg.				In place		

How (and to whom) have the lessons learnt relating to the recommendation been disseminated.
Information disseminated to MDT via action plan meetings, governance meetings and ward round.

Has the recommendation been escalated to the Local Risk Register for risk assessment and monitoring Yes/No.
No

Recommendation Identified (in Report/Review/CQC) Issue/ Driver/ Gap/ Objective requiring action	Outcome Measure of success. How will you know the actions have resolved the issues identified in the recommendation (a set target, percentage gain, audit results etc.)	Actions Stated clearly and concisely the actions to achieve the desired outcome.	Resource demand/ constraints Relevant to all people, any issues in completion	Person Responsible Initials	Person Accountable Initials	Target Date for Completion Realistic deadline	RAG Rating Status/ See Key	
Specific	Measurable	Specific and Achievable	Realistic			Time bound		
At the February 2015 inspection it was identified by CQC that patients were not effectively safeguarded from abuse. There had been 22 allegations of abuse by staff and that only 6 of these had been reported to the local safeguarding authority. Make provision so that there is a robust safeguarding reporting system.	Patients are protected from abuse by robust safeguarding procedures. Provide all staff further training to ensure they understand the proper reporting process on 'safe guarding'. Training and supervision to include, professional attitudes and behaviour, training around role modelling and accurate documentation and record keeping. Ensure evaluations of training are completed.	All wards have a safeguarding folder in the office. This supports and guides staff regarding safeguarding actions. Defensible documentation training commenced during November focusing on language and factual accuracy. Currently (as of 11/12) 89% of staff have completed safeguarding training. Training manager has written to safeguarding re accessing external training and resources from local safeguarding team. Training evaluations to be maintained by training manager and analysed to inform improvement.	Staff to attend safeguarding authority training in order to cascade further training within the hospital	David Ramage	Head of Compliance	30/09/2015		
		Safeguarding lead to build further links with external Local Authority Safeguarding Team. SW has now left Waterloo Manor and HD has taken on safeguarding lead until Senior Nurse Manager has completed induction. Several meetings with Lucy Cockrem and further dates given by HD. Awaiting date from LC and Maxine Naismith re meeting to discuss progress and training needs. Regular meeting schedule to be agreed with safeguarding authority for 2016.	Staffing/sg lead changes at WMH have had minor impact on progress during late 2015.	David Ramage/ Anne-Marie Osborne-Fitzgerald	Head of Compliance	31/03/2016		

		Invite Local SG Lead to the Hospitals Monthly Integrated Governance meetings. Safeguarding document completed with outstanding issues. *All documentation completed and forwarded to local safeguarding team for 7 outstanding. 2 remain - 1 currently with police and 1 awaiting advice from s/g re previous discussions with former SNM* HD has met with Lucy Cockrem and plans for sharing of information and future meetings agreed. Hospital integrated governance meetings are held on the third Monday of each month, with a standing invite to the safeguarding lead.	Information provided to, and awaiting further advice from, safeguarding authority	David Ramage	Head of Compliance	Invites sent. LC attending 25/01/16		
		Safeguarding and Incident Review/Analysis meeting to commence weekly. First meeting held on 04/09/15, with a follow up meeting in Oct, it has now been agreed that all IR and Safeguarding's will be reviewed from Monday 12th October daily during morning handover, thereby superseding the weekly review. Incident reports discussed at morning meeting daily, safeguarding identified, with follow up action delegated. Safeguarding is a standing agenda item in the monthly integrated governance meeting.		Anne-Marie Osbourne Fitzgerald (AMOF)	David Ramage	31/10/2015		
		Training dates have been sourced from Leeds Safeguarding Adults team of 23/01/16, 11/02/16 and 25/02/16. Staff have been allocated						

		to each date, with the plan to gather resources and deliver this training to staff at Waterloo Manor. Further training dates will be requested for both level 1 and level 2 safeguarding training and staff allocated to dates.						

How (and to whom) have the lessons learnt relating to the recommendation been disseminated.
Where outstanding safeguarding issues remained, individual charge nurses have been tasked with completing outstanding documentation and submitting to local authority. Training manager has been copied in to communication from safeguarding regarding attendance at external training. All safeguarding discussions take place during morning meeting with members of the MDT.

Has the recommendation been escalated to the Local Risk Register for risk assessment and monitoring Yes/No.
No

Recommendation Identified (in Report/Review/CQC) Issue/ Driver/ Gap/ Objective requiring action	Outcome Measure of success. How will you know the actions have resolved the issues identified in the recommendation (a set target, percentage gain, audit results etc.)	Actions Stated clearly and concisely the actions to achieve the desired outcome.	Resource demand/ constraints Relevant to all people, any issues in completion	Person Responsible Initials	Person Accountable Initials	Target Date for Completion Realistic deadline	RAG Rating Status/ See Key	
Specific	Measurable	Specific and Achievable	Realistic			Time bound		
To improve the completion of paperwork / reporting at ward level. **CQC, in February 2015 found that care plans were not holistic and person-centred and they did not demonstrate that patients were adequately involved in developing their care and treatment.**	Provide training for all relevant staff to have a better understanding of documenting, reporting and recording. Documentation will evidence patient input/involvement wherever possible.	Training sourced and letter informing staff of training to be sent, with a target of 90% of staff trained by 31/03/2016 Training sessions delivered 19/10/15 and 09/11/15. Further training delivered 17 & 18/11/15. 61% of nursing and support staff have been trained. Evidence of improved documentation on electronic handover sheets in morning meeting.	Ensure remaining staff have undertaken defensible documentation training and evaluations completed and analysed to inform improvement.	Rachel Wakelin	AMOF	31/03/16		
How (and to whom) have the lessons learnt relating to the recommendation been disseminated. **Defensible documentation training delivered by HD to 61% of ward based staff, with rationale for staff regarding what CQC found and how documentation can be improved.**								

Recommendation Identified (in Report/Review/CQC) Issue/ Driver/ Gap/ Objective requiring action	Outcome Measure of success. How will you know the actions have resolved the issues identified in the recommendation (a set target, percentage gain, audit results etc.)	Actions Stated clearly and concisely the actions to achieve the desired outcome.	Resource demand/ constraints Relevant to all people, any issues in completion	Person Responsible Initials	Person Accountable Initials	Target Date for Completion Realistic deadline	RAG Rating Status/ See Key	
Specific	Measurable	Specific and Achievable	Realistic			Timebound		
Addressing staff behaviours and attitudes. **CQC found that patients did not feel cared for and feedback about staff interactions was negative. 'The staffing culture in the hospital was poor'. 'Staff appeared to lack interest and did not engage in providing good quality care to patients'.**	Utilise values based recruitment screening and interview procedures to recruit new staff with appropriate values. Psychology to source compassion survey for staff, collate results and follow-up with appropriate training.	New Hospital Director commenced September 1 and has developed a screening tool supporting values-based recruitment processes. He has discussed compassion survey with psychology, who will source and implement. Compassion survey sent to all staff on 25/09/2015 evaluation to be complete by 31/12/2015. HD will meet with individual staff groups to raise awareness of attitude and culture and identifying steps to support positive, respectful relationships and language in everyday interactions with patients. Values based screening tool in operation. Evaluation of compassion survey. Meeting with staff groups to be commenced 8th Oct. Minutes of nurse meetings. Senior HCW meetings planned for 14 & 15 October 2015. HCW meetings planned for December 30 2015 and January 6 2016.	HD facilitating meetings in order for both shift teams to be able to attend.	Psychology department Collating results of survey to support the identificatio n of further training needs	David Ramage	31/12/2015		

How (and to whom) have the lessons learnt relating to the recommendation been disseminated.
The CQC feedback regarding staff culture and attitudes forms part of the defensible documentation training, in which dignity, respect, language and subjective opinion are discussed, with positive and negative examples used to inform debate.

Has the recommendation been escalated to the Local Risk Register for risk assessment and monitoring Yes/No.

Recommendation Identified (in Report/Review/CQC) Issue/ Driver/ Gap/ Objective requiring action	Outcome Measure of success. How will you know the actions have resolved the issues identified in the recommendation (a set target, percentage gain, audit results etc.)	Actions Stated clearly and concisely the actions to achieve the desired outcome.	Resource demand/ constraints Relevant to all people, any issues in completion	Person Responsible Initials	Person Accountable Initials	Target Date for Completion Realistic deadline	RAG Rating Status/ See Key
Specific	Measurable	Specific and Achievable	Realistic			Time bound	
Provide Ward Staff Training for Activities **CQC found that 'patients spent hours of time sat around with very little to do. Staff appeared to lack interest and did not engage in providing good quality care to patients. For example, we found staff spent considerable time sat on sofas in communal areas with up to eight patients at a time and were not seen to offer activities or motivate patients to participate in anything therapeutic'.**	Agree training programme as per individual patients care plan for ward staff to engage in activities with patients.	New documentation implemented 5/10/2015 and will be reviewed by OT and in QGM on 16/10/2015, and will be part of the My Shared Pathway training delivered by Regional Involvement Leads Attendance register with RW, Training delivered on 19th October and 9th November. 61% of ward based staff have undertaken training. Further training for remaining staff to be implemented by 31/03/16 Staff satisfaction survey to be carried out in January 2016. Evaluations of training delivered to be collated by training manager.	Training delivered to 61% of front line staff, with further dates to be scheduled.	Francis Cornelius	David Ramage	31/03/16	
		Update from Frances Cornelius 17-12-15. Progress: (new- 17/12/15) activity audit documentation has been successfully implemented in all wards. Training has been delivered to 61% of nursing and care staff. OT and involvement team collect and input the information on the shared drive to measure actual activities engaged in by patients. October completion of forms were still limited (82 hours recorded for one patient) comparing to actual activities engaged in, but November input shows a clear improvement (94 hours for the same patient) of				Documentation in place. Further training for remaining staff to be delivered by 31/03/16	

		recording the actual activities engaged in. it also demonstrated a clear understanding of staff (especially care staff) of the importance of activity engagement. OT staff reports daily support seeking from ward staff regarding the activities the patients engage in. Action required: review of documentation and any issues of recording data. Improved consistency in documentation of activities in November IG meeting. Action required: (new) OT staff plans to review all patient activity programmes in January which will be accompanied by risk and motivation guidelines specific to the patient. (aim; to complete 10 patients per month.)						
		The occupational therapy team have allocated a team member to each ward for half a day per week in order to further develop ward-based activities and provide role modelling for support staff.						

How (and to whom) have the lessons learnt relating to the recommendation been disseminated.
Training has been delivered to 61% of ward based staff by Francis Cornelius, lead OT, along with rationale for staff regarding why the training has been necessary.

Has the recommendation been escalated to the Local Risk Register for risk assessment and monitoring Yes/No.
No

Recommendation Identified (in Report/Review/CQC) Issue/ Driver/ Gap/ Objective requiring action	Outcome Measure of success. How will you know the actions have resolved the issues identified in the recommendation (a set target, percentage gain, audit results etc.)	Actions Stated clearly and concisely the actions to achieve the desired outcome.	Resource demand/ constraints Relevant to all people, any issues in completion	Person Responsible Initials	Person Accountable Initials	Target Date for Completion Realistic deadline	RAG Rating Status/ See Key	
Specific	Measurable	Specific and Achievable	Realistic			Timebound		
Night Shift Worker to work % of day shifts in a given time scale. CQC found that 'staff did not receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.'	Review the duty rota and agree programme to ensure there is effective rotation of staff between night and day shifts. This to include leadership provision on night shifts.	Staffing teams have been reviewed, with night staff working 2 weeks per quarter on days this will commence on the 1st January with Charge Nurses overseeing. DR has discussed with AC the creation of senior staff nurse positions, with a view to supporting charge nurses and providing leadership support to night staff. All night staff will have undertaken two weeks' of day duties within each quarter, with evidence documented on rotas and staff personal records. New rotas commence on 12/10/2015. New Senior Nurse manager will oversee the implementation of night/day rotation, with a documented quarterly review.	Rotation will be on a rolling individual basis, rather than whole team, in order to maintain stability and consistency within established teams	AMOF	David Ramage	First documented review due 31/03/2016		

How (and to whom) have the lessons learnt relating to the recommendation been disseminated.
Night staff have been made aware during meetings and supervisions that they are required to rotate on to day shifts for at least two weeks each quarter.

Recommendation Identified (in Report/Review/CQC) Issue/ Driver/ Gap/ Objective requiring action	Outcome Measure of success. How will you know the actions have resolved the issues identified in the recommendation (a set target, percentage gain, audit results etc.)	Actions Stated clearly and concisely the actions to achieve the desired outcome.	Resource demand/ constraints Relevant to all people, any issues in completion	Person Responsible Initials	Person Accountable Initials	Target Date for Completion Realistic deadline	RAG Rating Status/ See Key	
Specific	**Measurable**	**Specific and Achievable**	**Realistic**			**Timebound**		
Supervision and Appraisals CQC found that 'staff did not receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.'	Supervision and appraisals to be maintained at 90% or higher. Supervisions will be analysed quarterly by HD/SNM to identify themes/trends and address as appropriate. Training figures will be collated monthly and discussed as a standing agenda item in integrated governance meetings, with actions identified and delegated.	Supervision will be maintained on a rolling three monthly programme. With HD supervising Charge Nurses monthly during which supervision and appraisal figures for each ward are reviewed with responsible charge nurse. As of 11/12 supervisions stand at 78% and appraisals 81%. By 31/01/16 supervisions and appraisals will be at a minimum of 90%	Charge nurses to supervise nurses and cascade to support workers.	Rachel Wakelin	AMOF	31/01/2016		
		Training statistics will be collated and disseminated. They will form part of the individual supervision discussions with charge nurses.		Rachel Wakelin	AMOF			

How (and to whom) have the lessons learnt relating to the recommendation been disseminated.
Supervisions and appraisals have been discussed and documented as part of individual charge nurse supervisions, with the statistics collated on an individual ward basis.

Has the recommendation been escalated to the Local Risk Register for risk assessment and monitoring Yes/No.
No

Recommendation Identified (in Report/Review/CQC) Issue/ Driver/ Gap/ Objective requiring action	Outcome Measure of success. How will you know the actions have resolved the issues identified in the recommendation (a set target, percentage gain, audit results etc.)	Actions Stated clearly and concisely the actions to achieve the desired outcome.	Resource demand/ constraints Relevant to all people, any issues in completion	Person Responsible Initials	Person Accountable Initials	Target Date for Completion Realistic deadline	RAG Rating Status/ See Key	
Specific	Measurable	Specific and Achievable	Realistic			Timebound		
Morning Meeting - Risks, Incidents and Complaints discussed daily and appropriate action / documentation update to reflect where needed. **CQC found that 'staff did not recognise concerns and failed to act appropriately in response to incidents or near misses. When concerns were raised or things went wrong, the response to reviewing and investigating causes was insufficient or slow. There was little evidence of learning from events with a lack of clear actions taken to improve safety'.**	Multidisciplinary attendance at morning meeting to review the previous day's incidents and/or positive occurrences. Focus on risks posed when discussing incidents and the management of this. Reflect on incidents. Complaints discussed from previous day (where raised). Safeguarding issues discussed from previous day (where raised). Action points identified with delegated individuals identified.	Director of compliance to audit documentation regarding risk and links to care plans (12/10/15), Audit completed. DR has circulated to teams to action. Charge nurses currently tasked with ensuring care plans are in place where risks are identified. Care plan audit documented to be updated taking into account the newly established 'My Recovery Plan' document.	None	Head of Compliance	Operations Director	31/10/15		
		Regional Involvement Leads providing training on My Shared Pathway commenced on 19/10/2015. 61% of staff have received MSP training. New 'My recovery plan' document implemented, encompassing ward round, START risk assessment and nursing/MDT care plans. This document will be reviewed fortnightly, ensuring that care plans and risk assessments are reviewed/updated by the MDT at least fortnightly. All patients to have the new document in operation by 11/01/16 New index to be implemented to simplify case notes.	Further training from involvement leads to be scheduled.	David Ramage	Head of Compliance	31/03/2016		
		Clinical Services Manager collates and reviews all incident report with the team in morning meeting. Incident reports are rated by the	None	AMOF	David Ramage	31/12/2015		

		team and signed off by the CSM						

How (and to whom) have the lessons learnt relating to the recommendation been disseminated. **This has been the focus of MDT discussions in governance meetings with sub-meetings to plan new documentation and review IR1 forms.**
Has the recommendation been escalated to the Local Risk Register for risk assessment and monitoring Yes/No. **No**

Recommendation Identified (in Report/Review/CQC) Issue/ Driver/ Gap/ Objective requiring action	Outcome Measure of success. How will you know the actions have resolved the issues identified in the recommendation (a set target, percentage gain, audit results etc.)	Actions Stated clearly and concisely the actions to achieve the desired outcome.	Resource demand/ constraints Relevant to all people, any issues in completion	Person Responsible Initials	Person Accountable Initials	Target Date for Completion Realistic deadline	RAG Rating Status/ See Key	
Specific	Measurable	Specific and Achievable	Realistic			Timebound		
Developing Charge Nurses **CQC verbal feedback from August 2015 was that 'charge nurses need to manage properly**	First Line Management Course to include effective leadership and management of staff and clinical areas. SNM to ensure effective supervision/support and guidance.	RW has sourced relevant information on management courses. One Charge Nurse has a BA in Managing in Health Care Organisations but is willing to attend further management training. Essential skills for first line managers - ACAS booked for 10/02/2016 for 4 charge nurses. Course discussed with charge nurses during supervisions. Further modules are available to charge nurses following completion of first module. Charge nurses to complete evaluation of module on completion.	Time and financial cost of course for 4 charge nurses	Rachel Wakelin	AMOF	First module 29/02/2016		

How (and to whom) have the lessons learnt relating to the recommendation been disseminated.

First line management course discussed with charge nurses during supervisions. All charge nurses informed of the date for the 'Essential Skills for First Line Managers' module.

Has the recommendation been escalated to the Local Risk Register for risk assessment and monitoring Yes/No.

No

<table>
<tr><th>Recommendation Identified (in Report/Review/CQC)
Issue/ Driver/ Gap/ Objective requiring action</th><th>Outcome
Measure of success. How will you know the actions have resolved the issues identified in the recommendation (a set target, percentage gain, audit results etc.)</th><th>Actions
Stated clearly and concisely the actions to achieve the desired outcome.</th><th>Resource demand/ constraints
Relevant to all people, any issues in completion</th><th>Person Responsible
Initials</th><th>Person Accountable
Initials</th><th>Target Date for Completion
Realistic deadline</th><th colspan="2">RAG Rating
Status/ See Key</th></tr>
<tr><td>Specific</td><td>Measurable</td><td>Specific and Achievable</td><td colspan="3">Realistic</td><td colspan="3">Timebound</td></tr>
<tr><td rowspan="2">To ensure Discharge Plans are in place for all patients
CQC verbal feedback in August was that all patients have a discharge plan….'you need to focus on what they will need when they leave, building relationships outside the service….ensuring they are at the right stage in their pathway'</td><td rowspan="2">Clinical Team to build and establish networks and relationships with external stakeholders in order to create realistic and achievable discharge plans. All patients to have realistic discharge plans in place.</td><td>External stakeholders are being invited to attend WMH and meet the "team" Charge Nurse and NIC have been given contact details of stakeholders and informed that they should be contacting them regularly to keep them up dated of progress, obs etc.… discharge plans are now documented in My Shared Pathway and reviewed during ward rounds and CPAs.
Weekly meeting with NHSE on Monday pm to discuss discharge pathways for low secure patients.</td><td></td><td>David Ramage</td><td>Operations Director</td><td>31/03/2016</td><td></td><td></td></tr>
<tr><td>Accessing the local community in preparation for discharge, patients are supported to attend college in Leeds. Several patients attend local charities for voluntary work, eg Dogs Trust and British Heart Foundation. Local charities providing engagement opportunities, eg 'Inkwell' arts and crafts centre, are well attended by patients, either escorted/unescorted according to risk assessment. Local gym/swimming pool are accessed in preparation for healthier lifestyle choices.
All patients are supported to cater for themselves where appropriate/able.</td><td>Continued support from staff/MDT to access external opportunities in preparation for moving into the community.</td><td></td><td></td><td></td><td></td><td></td></tr>
</table>

How (and to whom) have the lessons learnt relating to the recommendation been disseminated.
Waterloo Manor has continued to discharge patients throughout the period of the voluntary embargo. Over 90% of discharges have been 'positive', ie to conditions of lower security or to the community.
Has the recommendation been escalated to the Local Risk Register for risk assessment and monitoring Yes/No.
No

Green	**Green**	Achieved
Green	**Amber**	Work is in progress in line with target date
Amber	**Amber**	Initial work has commenced appropriate to target date
Amber	**Red**	Minimal or no work has commenced in this area due to the long lead time
Red	**Red**	Actions have not been achieved by the target date
Grey	**Grey**	Responsibility reallocated