Maidstone and Tunbridge Wells NHS
NHS Trust

CQC Quality Improvement Plan

Assurance Report May 2015

This report is produced to provide staff, patients, stakeholders, the CQC and the board with an assurance against the Quality Improvement Plan developed and agreed in response the CQC inspection report that was published in February 2015. This is a monthly report (commenced April 2015 onwards), following which the main Quality Improvement Plan will be updated

The report will be submitted to the Trust Management Executive, the Trust Board, TDA and the CQC and will be shared with local commissioning groups. A summary will be published on the MTW intranet and MTW website.

The first section presents the progress of the Enforcement notice and Compliance action. The second section provides information about the progress on the 'Should do' actions to date.

Overview of progress to date

Enforcement action – Water testing Maidstone Hospital

The enforcement notice relating to annual water sampling for legionella was responded to immediately with actions undertaken to address the issue and ensure governance is now place to prevent the risk of re-occurrence. Further information requested by the CQC has been submitted along with a request for the enforcement notice to be lifted. We are waiting for the CQC to review the information sent and advise on the next steps.

Compliance actions – Paediatrics

A validated paediatric early warning system has been identified and agreed for implementation at MTW. A paper version has been implemented in paediatric emergency department both sites, with intention to roll out to all paediatric departments in July 2015. This validated tool will also be used on Nervecentre (inpatient electronic recording system)

The Standard Operating Procedure (SOP) for the administration for topical anaesthetics for children has been completed and agreed. Training for senior staff to undertake PGD's is underway and due to be completed by the end of May. In the interim topical anaesthetic continues to be prescribed. Regular audits are undertaken to assess compliance.

Compliance actions – Critical care

Significant progress has been made in addressing the compliance actions against Critical Care. Morning wards rounds take place simultaneously at weekends and the second evening ward round takes place either in person or via telephone depending on acuity of patients. An agreement have been reached to enable the implementation of a second ward round at weekends consistently and to initiate an intensivist rota in line with the requirements of ICS standards. Recruitment for additional Consultants to support the rota continues.

Further work is ongoing to review the standard operating procedure for managing critically ill patients requiring ITU when capacity is challenging. There has been a significant improvement in reducing the number of ITU patients from ITU to wards out of hours (22.00 and 07.00).

The critical care outreach service is currently being recruited into, with a consultation paper to develop a 27/7 service being prepared for formal consultation.

Compliance action – meeting the needs of service users

An interim lead has been appointed in May who will lead the recruitment of a permanent Equality and Diversity lead and commence the work to meet the needs of service users with due regard to their cultural and linguistic background and any disability they may have.

Status of plan

Rating below relate to the progress of the enforcement/compliance action as a whole based on the date of **overall completion**. Some of the original actions, once completed have resulted in other actions being required which is simply an evolution of the situation for example compliance action 2, action 3b

The table below provides a summary of any issues arising.

KEY to progress rating (RAGB rating)

	Blue	Fully Assured
	Amber	More assurance required
	Green	Assured / in progress
	Red	Not assured

	Operational lead	Progress rating	Issues / Comments
Enforcement Notice – Water testing	Jeanette Rooke, Director of Estate & Facilities		Action completed and evidence submitted to CQC for review. Request for enforcement notice to be lifted.
CA 1 - Paediatric Early Warning Scoring (PEWS) system	Jackie Tyler, Matron Children Services		None raised
CA 2 – ICU weekend cover	Daniel Gaughan General Manager, Critical Care		Significant progress with ward rounds at weekends, review and agreement on intensivist rota that will meet ICS requirements, expected full compliance by October 2015 with new rota. Risks assessed and mitigation in place in the meantime.
CA 3 – ICU consultant within 30mins	Daniel Gaughan General Manager, Critical Care		

CA 4 – ICU delayed admissions	Jacqui Slingsby Matron, Critical Care Directorate		None raised
CA 5 – ICU delayed discharges	Jacqui Slingsby Matron, Critical Care Directorate		None raised
CA 6 – ICU overnight discharges	Jacqui Slingsby Matron, Critical Care Directorate		Robust patient tracking in place, however continued concern in relation to patient flow at TWH which impedes patients having timely transfers (before 22.00hrs). Plan in place to create additional capacity at TWH
CA 7 – Critical Care Outreach 24/7 service provision	Siobhan Callanan Associate Director of Nursing		None raised
CA 8 – ICU washing facilities	Jacqui Slingsby Matron, Critical Care Directorate		Improvements in facilities, action nearly completed
CA 9 – Cultural/linguistic needs	Richard Hayden Deputy Director of Workforce		None raised
CA 10 – CDU Privacy and dignity	Lynn Gray Associate Director of Nursing		Awaiting definitive decision on preferred option
CA 11 – Medical records	Wilson Bolsover Deputy Medical Director		None raised
CA 12 – Security staff	John Sinclair Head of Quality, Safety, Fire and Security		None raised
CA 13 – Incident reporting	Jenny Davidson Associate Director of Governance, Patient Safety and Quality		None raised
CA 14 – Joint management of children with surgery	Hamudi Kisat / Johnathan Appleby Clinical Directors		None raised
CA 15 – Children's Clinical governance	Karen Woods Risk and Governance Manager, Children and Women's Services		None raised
CA 16 – Incident reporting + lessons learnt	Jenny Davidson Associate Director of Governance, Patient Safety and Quality		Completed compliance action
CA 17 – Corporate	Jenny Davidson Associate Director of Governance,		None raised

clinical governance	Patient Safety and Quality		
CA 18 – Topical anaesthetics	Jackie Tyler, Matron Children Services		None raised

Enforcement Notice

Enforcement Action			REF	Directorate	Issue Identified	Action /s	Lead	Date to be completed	Evidence Required	Outcome/success criteria
Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 – Cleanliness and Infection Control Cleanliness and infection control 12. (1) The registered person must, so far as reasonably practicable, ensure that – (a) Service users; (b) Persons employed for the purpose of the carrying on of the regulated activity; and (c) Others who may be at risk of exposure to a health care associated infection arising from the carrying on of the regulated activity, are protected against identifiable risks of acquiring such an infection by the means specified in paragraph (2), (2) The means referred to in paragraph (1) are (a) The effective operation of systems designed to assess the risk of and to prevent, detect and control the spread of a health care associated infection; People who use services and others were not protected against the risks associated with health care associated infections because the trust had failed to ensure that an effective operation of systems designed to assess the risk of and to prevent, detect and control the spread of health care associated infections, with specific regard to water quality and safety and more specifically, themanagement and control of Legionella. Regulation 12(1)(a)(b)(c)(2)(a)(c).	**Executive Lead: Glenn Douglas**	**Date compliance will be achieved by: January 2015**	**EN1**	Estates and Facilities Management	The annual water sampling for legionella was six months overdue at Maidstone Hospital	1. Internal Investigation undertaken 2. External review undertaken 3. Water Hygiene Management Action Plan developed and implemented 4. Governance around water hygiene management reviewed and new system of robust Governance implemented 5. Risk Assessments and Sampling testing undertaken 6. Authorised Engineer (Water) appointed 7. Estate Management and Audit review of processes with a number of new appointments have been made within the senior team of Estates Services ensuring Authorised Persons in each technical element. The planned preventative maintenance schedule is currently being reviewed to ensure all statutory requirements are incorporated. In addition a comprehensive schedule is being developed for audit purposes. The internal auditing will be triangulated by the inspections, risk assessments and annual report undertaken and issued by the Authorised Engineer (Water) who provides the independent assurance and validation.	Jeanette Rooke	Completed 14th January 2015	Report produced outlining Governance, testing results and audit processes External review report Certificates of sampling Ongoing Agenda and Minutes of meetings	Water hygiene Management is compliant with statutory requirements with robust governance and management in place

Report submitted with all actions completed. Request for Enforcement notice to be lifted submitted with supporting evidence. RAGB = BLUE

Compliance action 1				CA1
Issue: *The PEWS system had not been validated and was not supported by a robust escalation protocol that was fit for purpose and was not standardised across the children's' directorate*				
Lead: *Hamudi Kisat, Clinical Director*		**Operational Lead: Jackie Tyler,** *Matron*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. PEWS chart reviewed in line with tertiary referral centres (Nottingham) or PEWS from National Institute for Innovation (used in other Trusts)	-Meeting with Nottingham Children's Hospital completed, authorisation given to adapt their PEWs paperwork - Awaiting final proof from Printers of new PEWs chart - Sepsis 6 incorporated - Chart will then go to relevant committees for approval.	1. Validated PEWS in place. 2. Revised escalation protocol in place 3. Staff competent and consistent in using PEWS and escalation. 4. 3 monthly audit of compliance 5. Evidence of communicatio n via meetings	31/6/15	
2. Escalation protocol reviewed alongside the PEWS chart review	Escalation protocol available in all areas for PEWs			
3. Once agreed, PEWS chart and escalation protocol implemented across Children's services directorate via teaching sessions, ward level meetings, A&E and Children's services Clinical Governance meeting	Paeds ED TWH now have PEWs score on Casualty care and current charts available in department Paeds ED MH trialling attachment of PEWs chart to casualty card – due to rolled out across sites July 15 Clinical skills facilitator in post to facilitate staff training			
PHASE 2 Electronic solution (Nervecentre) for PEWS and escalation implemented (brought forward within existing IT plan). NB excludes paediatric A&E	Senior nurse attendance at Nervecentre meetings Awaiting roll out of paperwork and trialling that before moving to electronic possibly September launch	6. Compliance audit from Nervecenter	31/12/15	
Action Plan running to time: Yes				
Evidence submitted to support update (list): Awaiting paper Pews documentation from printers and copy of ED casualty card from Maidstone and Tunbridge Wells NHS Trust				
Assurance statement :				
It has been identified that the introduction of a new PEWS chart to the wards must be done in a planned and controlled method. The trust is confident that in the interim, with the new escalation process in place, and the current PEWS tool, children who are at risk of deterioration are identified appropriately.				
Areas of concern for escalation:				
None				

Compliance action 2				CA2
Issue: *Contrary to the core standards of the Intensive Care Society: There was a lack of cover by consultants specialising in intensive care medicine at weekends; for example, one consultant covered more than 15 patients on two sites.*				
Lead: *Greg Lawton , Clinical Director*		**Operational Lead:** *Daniel Gaughan, GM*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Morning week-end ward rounds on both units implemented	Implemented January 2015	1. Anaesthetic electronic rota showing allocation of intensivists at weekends to site allocation 2. Business plan including risk assessment, mitigations and staffing analysis against core standards 3. TME Meeting minutes where business case considered and decision made 4. Audit of patients medical notes documenting weekend Consultant reviews	1/2/15	
2a. Second ward round at weekend is taking place at both units. Risk assessment undertaken with mitigations in place as required 2b. Second ward round at weekend in person	2a. Second ward round at weekends is taking place in person or by phone depending on acuity of patients. 2b. Agreement for amendments on rota to enable a 1-8 compliant rota to ensure a second ward round in person at weekends to occur consistently.		2a. 31/3/15 2b. 1/10/15	
3a. The rota for the intensivists reviewed in line with the requirements of the ICS core standards 3b. Rota fully meeting the ICS requirements	3a. Rota has been reviewed and agreement reached to meet ICS requirements. 3b. Decision made to implement a 1-8 compliant rota, implementation - September 2015.		3a. 31/3/15 3b. 1/10/15	
4. Business case for additional intensivists developed and considered	Final draft to be completed. Exec sign off and TME agreement June.		17/6/15	
5. Mitigation in place for non-compliance	Mitigation part of CQC intensivist risk assessment		30/6/15	
6. Recruitment achieved	Re advertising intensivists job June 2015		1/4/16	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list): Risk Assessment + Rota				
Assurance statement :				
Significant progress with agreement to change in intensivist rota				
Areas of concern for escalation:				
Appointment of suitability qualified intensivists				

Compliance action 3				CA3
Issue: *Contrary to the core standards of the Intensive Care Society: The consultant was not always available within 30 minutes. There was only one ward round per day when there should be two to comply with core standards.*				
Lead: *Greg Lawton , Clinical Director*		**Operational Lead:** *Daniel Gaughan, GM*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Travel times & distance for each consultant being reviewed to assess compliance with 30 minutes availability for each individual consultant.	This has now been assessed by the Clinical Director	1. Report from Clinical Director outlining each Consultant's travel distance and confirmation of each Consultants ability to respond within 30 minutes. 2. Any delays in responding to be reported as incidents (DATIX) 3. Audit of patients medical notes documenting weekend Consultant reviews	31/5/15	
2. Risk assessment to be undertaken where travel times exceed 30mins	This has been completed to support mitigation until new rota commences in September 2015		31/5/15	
3. Ward round compliance actions in CA2	3a. Second ward round at weekends is taking place in person or by phone following a risk assessment. 3b. Agreement for amendments on rota to enable a 1-8 compliant rota ensuring a second ward round in person at weekends		3a. 31/3/15 3b. 1/10/15	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list): Risk assessment				
Assurance statement :				
Fully compliant rota expected September 2015				
Areas of concern for escalation:				
Appointment of consultant intensivists.				

Compliance action 4				CA4
Issue: *Contrary to the core standards of the Intensive Care Society: Admissions were delayed for more than four hours once the decision was made to admit a patient to ICU*				
Lead: *Richard Leech, Clinical Director*		**Operational Lead:** *Jackie Slingsby, Matron & Lynn Gray, ADN emergency services*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Consider option of ringfencing ITU bed for admission	Discussion and agreement at TME: the ringfencing of ITU bed will be implemented where possible	1. Minutes of TME meeting where ringfencing option discussed 2. SOP for ITU admissions, transfers and discharges. SOP for managing critically ill patient when ITU is full 3. Site report documentation 4. Monthly performance data 5. DATIX IR1 completed for each patient who has a delayed admission to ITU due to inability to move wardable patients. Investigation into each occurrence with clear lessons learnt and changes implemented	20/5/15	
2. Standard Operating Procedure developed relating to ITU admissions	Operational Policy which incorporates admission policy reviewed and comments made. For approval at ICU meeting on 21/5/15		31/5/15	
3. Review SOP for managing critically ill patients requiring ITU, when ITU capacity is full (for e.g. in recovery)	Task and finish group of all stakeholders working on pathways for patients in escalation areas. Preliminary work re-visited and updated based on different scenarios		30/4/15	
4. ITU referrals & those patients requiring ITU will be identified and discussed at each site meeting and priorities escalated as appropriate.	Attendance at each site meeting by Shift leader/matron in place. Associate Director responsible for the site ensures ITU capacity and demand is discussed at each site meeting and plans put in place with clinical teams to transfer out as appropriate. ITU referrals will be consultant to consultant and raised to both the Clinical site team and Matron/Shift leader in ICU. Clinical priorities will be identified by the Consultant intensivist		1/4/15	
5. When no prospect of ITU capacity available on either site then arrangements for transfer to another unit will be made.	Consider escalation feasibility before any transfer. Critical care capacity within Trust reviewed before transfer outside of organisation. National Emergency bed service already in place.		1/1/15	
Action Plan running to time: **No**				
Evidence submitted to support update (list): Operational policy				
Assurance statement :				
Areas of concern for escalation:				
None				

Compliance action 5				CA5
Issue: *Contrary to the core standards of the Intensive Care Society: Discharges from the ICU were delayed for up to a week. Of all discharges, 82% were delayed for more than 4 hours*				
Lead: Greg Lawton, *Clinical Director*		**Operational Lead:** *Jackie Slingsby, Matron & Lynn Gray, ADN emergency services*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Standard Operating Procedure to be developed relating to ITU discharges	Operational Policy drafted. For agreement at next cross-site meeting 20/5/15.	1. SOP for ITU admissions, transfers and discharges. 2. Site report documentation. 3. Monthly performance data 4. DATIX incident report completed for each patient who has a delayed discharge from ITU Investigation into each occurrence with clear lessons learnt and changes implemented	31/5/15	
2. Transfers out of ITU to be followed up on a named patient basis at each site meeting	In place at site meetings		1/4/15	
3. To link in with Trust wide work around patient flow and delayed discharges improvement plan developed in line with D16 CQUIN and in collaboration with Chief Operating Officer and Clinical Site Management team	Monthly delayed discharge performance data captured on performance dashboard and within monthly unit reports. Performance against milestones reported at monthly CQUIN board. Incident forms completed for each delay, clinical site team identified as handlers.		30/5/15	
Action Plan running to time: Yes				
Evidence submitted to support update (list): Operational Policy, Delayed discharge list, ICU divisional dashboard, Site reports				
Assurance statement :				
Areas of concern for escalation:				

Compliance action 6				CA6
Issue: *Contrary to the core standards of the Intensive Care Society: Overnight discharges take place from the ICU.*				
Lead: Greg Lawton, *Clinical Director*		**Operational Lead:** *Jackie Slingsby, Matron & Lynn Gray, ADN emergency services*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. All ward fit patients to be identified to the site team at the earliest opportunity but by 1500 at the latest each day.	All patients deemed ward fit or likely to be fit are named at site meetings and entered on capacity handover form to the site team, together with any special requirements i.e. Side room needed, specialist ward etc. Displayed in site team on Comms board	1. Incident (DATIX) report to be raised on all post 2000hrs transfers. Review and identification of where lessons can be learnt and improvements made	1/3/15	
2. Transfer plans to be agreed and completed by 2000 hrs at the latest. **No patients to be routinely transferred from ITU after 2000.**	During April **7** patients at TWH (12 in March) and **0** at Maidstone (3 in March) were transferred to wards between 22:00 and 07:00, which is a significant improvement on March. Incident reports raised. Patients though deemed fit prior to these times were not able to be moved to a ward due to bed capacity issues.		1/3/15	
Action Plan running to time: Yes but capacity challenges continue to impact on delivery				
Evidence submitted to support update (list): Transfers out of hours spread sheet, ICU divisional dashboard, site reports				
Assurance statement :				
Robust Patient tracking in place				
Areas of concern for escalation:				
Concern in relation to patient flow at TWH continues, which impedes patients having timely transfers. Long term strategy for inpatient capacity at TWH in planning phase				

Compliance action 7				CA7
Issue: *The outreach service does not comply with current guidelines (National Confidential Enquiry into Patient Outcome and Death (NCEPOD) (2011))*				
Lead: *Greg Lawton, Clinical Director*		**Operational Lead:** *Siobhan Callanan, ADN planned care*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Business Case approved	Approved	1. Rota showing 24 hour / 7day cover 2. Review of service and performance data via Directorate Clinical Governance meetings	27/1/15	
2. Recruitment to posts	Currently 2.77 vacancies Further interviews to take place on 21st May 2015		1/9/15	
3. Implementation of a 24 hour 7 day out-reach service which will be fully integrated with critical care service	Consultation process underway		1/10/15	
Action Plan running to time: **Yes / ~~No~~**				
Evidence submitted to support update (list): Advert for outreach posts Draft consultation paper.				
Assurance statement :				
On track to deliver the plan, with good engagement across the teams and with support of the executive team				
Areas of concern for escalation:				
None				

Compliance action 8				CA8
Issue: *Improvements are needed in relation to the environment in the Intensive Care Unit with regards to toilet/shower facilities for patients.*				
Lead: *Greg Lawton, Clinical Director*		**Operational Lead:** *Jackie Slingsby, Matron*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Conversion of an existing toilet to a patient toilet & bathroom facility at Tunbridge Wells Hospital	Bathroom facility for patients have always been in place at TWH and contains a toilet within the shower room. The staff toilet which is co-located to the existing facility has been re-assigned and designated as a patient toilet, with appropriate signage	1. Photo of Toilet / shower facilities appropriate for patient use 2. Confirmation at Executive / Non Executive walkabout	1/4/15	
2. Provision of appropriate patient washing facilities within Critical Care at Maidstone Hospital	Shower room available and two designated patient toilets, one which has disabled access; all in use. Awaiting new shower chair delivery.		1/4/15	
Action Plan running to time:		**Yes**		
Evidence submitted to support update (list):				
Assurance statement :				
Photographs: Submitted with April update Non-Executive/Executive walk round at Maidstone – Avey Bhatia/Steve Tinton 13/4/15 at Tunbridge Wells – Paul Sigston 14/4/15				
Areas of concern for escalation:				
Outstanding action - New Shower chair ordered, awaiting delivery at Maidstone.				

Compliance action 9				CA9
Issue: *The provider did not ensure that care and treatment was provided to service users with due regard to their cultural and linguistic background and any disability they may have*				
Lead: *Richard Hayden, Deputy Director Human Resources*		**Operational Lead:** *Richard Hayden, Deputy Director Human Resources*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Appoint a dedicated lead for Equality and Diversity for Trust	Interim lead appointed during May 2015	1. Substantive E&D Lead Appointed 2. Training records against E&D awareness programme 3. New E&D Strategy 4. Detailed action plan for improvements 5. Evaluation of changes to service and feedback from staff (staff survey), patients, Healthwatch and community groups (with actions developed and monitored as required)	1/9/15	
2. Develop an E&D awareness programme for all staff			1/10/15	
3. Review and develop new E&D strategy for organisation, in collaboration with MTW staff and partner organisations			1/9/15	
4. Ensure current process for accessing translation services is communicated to all staff			1/2/15	
5. Identify an existing NHS centre of excellence and buddy with them to ensure best practice and learning implemented in a timely fashion			1/6/15	
6. Conduct a comprehensive review of all existing Trust practices in relation to E&D requirements - for example information, translation, clinical practices, food, facilities			1/4/16	
7. Develop links with local support groups and communities to engage them in the improvement plan for the Trust with assistance from Healthwatch			1/10/15	
8. Ensure appropriate organisational governance with assurance to Trust Board in relation to Equality and Diversity			1/9/15	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list):				
Assurance statement :				
Areas of concern for escalation:				
None				

Compliance action 10				CA10
Issue: *Dignity and privacy of patients was not being met in the Clinical Decisions Unit.*				
Lead: *Akbar Soorma, Clinical Director*		**Operational Lead:** *Lynn Gray, ADN emergency*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Options appraisal for addressing existing dignity and privacy issues in CDU (2 main options are Option 1: changing function of CDU or Option 2: provision of toilet facilities)	Options appraisal currently being developed to identify options to address privacy and dignity issues Meeting arranged with Estates Team to assist with development of proposals Report to Directorate Board	1. Options appraisal paper 2. Changes to CDU environment reviewed by link executives and reported at Standards Committee 3. Site report documentation	1/5/15	
2. Agree preferred option and implement	Report to Directorate Board		Option 1: 1/4/16 Option 2: 1/10/15	
3. Each patient to be tracked and discussed at each site meeting to ensure timeframes met and plan for discharge / transfer in place	Implemented at all site meetings and record of discussion to be recorded on site report documentation		1/4/15	
4. To link in with Trust wide work around patient flow and action TW30	Ensured outcomes are featured in the Escalation and Resilience policies.		30/5/15	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list): Yes				
Assurance statement :				
Compliance action 10 to ensure dignity and privacy of patients being met in Clinical Decisions Unit is progressing in line with agreed timeframes				
Areas of concern for escalation:				
Review of DSSA guidelines affecting options appraisal, financial and PFI constraints on estates work				

Compliance action 11				CA11
Issue: *The provider did not ensure that service users were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user.*				
Lead: *Paul Sigston, Medical Director*		**Operational Lead:** *Wilson Bolsover, Deputy Medical Director*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Reinforce requirements of Health Care Record keeping amongst multidisciplinary staff, including timely recording of actions undertaken by: 1a. Record Keeping champion for department who will be a source of information and support for record keeping standards 1b. Investigate the possibility of providing a name stamp for staff 1c. Staff involvement in record keeping audit	a) No progress at present. b) Legibility of names was not an issue (for junior doctors) so no major gains form this, which is perceived as difficult to implement. c) Audit will need to include the availability and completeness of the case records.	1. Minutes of Directorate Clinical Governance meetings 2. Staff audit pilot 3. Record keeping champion program and list 4. Report on name stamps for staff and recommendations 5. Induction programme for new doctors 6. Report from task and finish group on records	1a. 1/6/15 1b. 1/6/15 1c. 1/6/15	
2. Review induction programme for new Doctors to ensure adequate training provided.	a) Induction for trainees includes legibility of notes (15.4.15) b) Clinical Tutors asked to add in requirement to avoid loose papers (7.5.15) c) College tutors to be prompted about induction for non-training grades once (b) completed.		1/5/15	
3. Multidisciplinary Task and Finish group (sub-group of health records committee) to review current notes with fresh eyes and consider where improvements can be made	a) Discussed at CD Board (6.5.15). No perceived need to change the case note records ahead of implementation of electronic records.		1/6/15	
4. Record keeping audit to be included in case reviews at Directorate CG Meetings	Not commenced as yet		1/9/15	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list):				
Assurance statement :				
Work has commenced and is in progress				
Areas of concern for escalation:				
none				

Compliance action 12				CA12
Issue: *Contracted security staff did not have appropriate knowledge and skills to safely work with vulnerable patients with a range of physical and mental ill health needs.*				
Lead: *Jeanette Rooke, Director of Estates and Facilities*		**Operational Lead**: *John Sinclair, Head of Quality, Safety, Fire & Security*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Provide documentation outlining the joint partnership with our contractor in regards to the provision of training.	Draft proposal sent to Interserve, awaiting confirmation-The General Manager for IFM is on compassionate leave so unable to confirm at present	1. Agreed documentation on joint partnership arrangements 2. Induction Attendance / compliance report on all existing security staff to Security Group 3. TNA document 4. Report on training compliance to Security Group 5. Certificates of training 6. Certificates of training	1/5/15 New date: 1/7/15	
2. All contractors to attend the Trust approved and agreed Induction Training and attend the Trust mandatory training	All Security Staff have completed the mandatory Trust training courses apart from two new starters who are currently going through registration processes.		1/4/15	
3. Contractors to be included on the Training Needs Analysis document outlining all requirements, frequency and levels	This can be evidenced by the attached email evidencing our L&D confirming a place on a requested course.		1/5/15	
4. Review compliance with all training requirements against existing security team	Security Contractor have 100% compliance rate in accordance with BSIA and ACS		1/5/15	
5. The Security Manager to provide training logs for the SMART Risk Assessment Training undertaken through one to one sessions with all security officers.	Security Manager has completed SMART Risk Assessment Training with 95% of the personnel deployed to both sites. The remaining employees will receive said training by the scheduled action completion date. SMART- Safeguarding Managing Risk Tool. Used to assess high risk patients-Two officers to complete-this is due to shift patterns		1/5/15 New date: 1/7/15	
6. All current security staff to be booked onto and attend Mental Health Awareness Training and dementia awareness training	All contracted Security Staff have been booked on Mental Health Awareness Training and Dementia Awareness Training courses provided by the Trust. All staff will have completed all above training by August 2015. Course feedback reviews will be undertaken to ascertain whether further higher level of training is required to provide the necessary support to meet the appropriate needs.		1/8/15	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list):				
Assurance statement :				
This action is being discussed at monthly SLA meeting, next due 18th May 15				
Areas of concern for escalation:				

Compliance action 13				*CA13*
Issue: *The process for incident reporting did not ensure that staff were aware of and acted in accordance with the trust quality and risk policy.*				
Lead: *Avey Bhatia, Chief Nurse*		***Operational Lead:*** *Jenny Davidson, Assc Director Governance, Quality and Patient Safety*		
Actions	***Monthly summary update on progress***	***Evidence required***	***Action completion date***	***Rating***
1. Staff leaflet on Trust Quality and Risk Policy, including incident reporting process to be produced in collaboration with staff and distributed to existing staff and new starters at induction	*Leaflet completed*	*1. Leaflet + audit of distribution and staff engagement through survey* *2. fully implemented intranet and web page* *3. Datix Staff survey + reporting figures / by profession* *4. Education presentation + staff survey* *5. Newsletter every month*	*1/5/15*	
2. Governance page to be developed on the intranet and MTW website with clear signposting to Incident Reporting section	*Allocated lead for this work. Will be arranging a task finish group starting May to achieve this task. Bolder reporting incident button already changed on intranet front page*		*Intranet 1/6/15* *Website 1/10/15*	
3. Incident reporting process currently under review, with full collaboration with clinical staff, to improve reporting process and investigate possibility of hosting reporting portal on mobile media	*Draft proposal written and plan is to undertake some collaborative work with staff over next month*		*1/6/15*	
4. Education / update program on Governance, Quality and Patient Safety including incident reporting and learning lessons from incidents to be rolled out to all medical and nursing staff over next year	*Identified within team and included in Governance team strategy, this work will be supported by internal recruitment to patient safety manager secondment*		*1/9/15*	
5. Continue to publish articles on Governance Gazette Newsletter relating to incident reporting and learning lessons. Encourage staff to write their own articles for publication.	*Aprils Governance Gazette is a focus on leaning from incidents relating to sharps*		*monthly*	
Action Plan running to time: ***Yes***				
Evidence submitted to support update (list): *draft proposal + Governance Gazette+ leaflet*				
Assurance statement :				
This action plan has been commenced and leads identified.				
Areas of concern for escalation:				
Patient safety team is awaiting recruitment of a 6month secondment Patient Safety Manager who will help implement some of these required changes. Recruitment expected June 2015				

Compliance action 14				CA14
Issue: *The clinical governance strategy within children's services did not ensure engagement and involvement with the surgical directorate*				
Lead: *Hamudi Kisat, Clinical Director & Johnathan Appleby, Clinical Director*		**Operational Lead:** *Hamudi Kisat, Clinical Director & Johnathan Appleby, Clinical Director*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Meeting between senior clinicians and managers Children's services directorate and Surgical directorates to establish clear roles and responsibilities of the care of children on the paediatric ward	Draft SOP completed following discussions/meetings with relevant teams	1. Minutes of joint meeting 2. Standard Operating Procedure 3. Audit of practice 4. MTW Clinical Governance Strategy 5. Agenda, Minutes and attendance records from CG meetings	1/5/15	
2. Standard Operating Procedure for care of children on surgical pathway on paediatric wards	Draft SOP completed –circulated for comment Patients now being admitted under surgical teams with paediatrician involvement		1/6/15	
3. Implementation of the SOP into routine daily practice	Awaiting for above actions to conclude		1/8/15	
4. Trust to develop a consistent approach to Clinical Governance through MTW Clinical Governance Strategy developed in collaboration with internal and external stakeholders	Awaiting feedback on outline of clinical governance approach in SOP		1/9/15	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list): draft SOP				
Assurance statement :				
This action plan is running to time currently				
Areas of concern for escalation:				
None				

Compliance action 15				CA15
Issue: *The children's directorate risk register did not ensure that risks are recorded and resolved in a timely manner.*				
Lead: *Hamudi Kisat, Clinical Director*		**Operational Lead:** *Karen Carter-Woods, Risk and Governance Manager*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. A full review of the directorate risks	Completed	1. Risk register shows children's section managed in a timely manner 2. Minutes of Directorate meeting / Clinical Governance meeting	1/5/15	
2. An update session for all senior nursing and medical staff on the purpose and process of the risk register	Update session carried out on the nurse update day 23rd April & at Clinical Governance meeting May 14th. Updates for junior staff will be continuing over next month		16/6/15	
3. Ensure review of risk register is standing agenda item at Directorate meetings / Clinical Governance meetings	Already standing agenda item at Directorate meetings Now standing agenda item at Paediatric Clinical Governance meeting		16/6/15	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list): Directorate R&G report **(**March). Awaiting revised risk register				
Assurance statement :				
Heightened awareness of staff involvement in paediatric risks ongoing within the directorate				
Areas of concern for escalation:				
Nil				

Compliance action 16				CA16
Issue: *There were two incident reporting systems, the trust electronic recording system and another developed by consultant anesthetists and intensivists one for their own use. The trust could not have an overview of all incidents and potentially there was no robust mechanism for the escalation of serious incidents. Therefore opportunities were lost to enable appropriate action to be taken and learn lessons.*				
Lead: *Avey Bhatia, Chief Nurse*		**Operational Lead:** *Jenny Davidson, Assc Director Governance, Quality and Patient Safety*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Anaesthetic incident reporting pilot discontinued. Those involved in running this system, and other clinical staff fully engaged with the review on the DATIX system to improve reporting process	Confirmation e-mail from the lead for the anaesthetic pilot that this is discontinued. Meeting regarding Datix improvements due May	1. Written Confirmation from coordinator of system 2. Leaflet audit of distribution and staff survey 3. Newsletter article 4. Increased incident reporting through single reporting system from anesthetist and intensivists	1/2/15	
2. Staff leaflet to include reminder about rationale for single reporting system	Leaflet completed		1/5/15	
3. Reminders in Governance Gazette and via intranet and website about the SINGLE reporting system in the Trust.	In May's edition of the Governance Gazette		1/5/15	
4. Assc. Dir. Quality, Governance and Patient Safety to attend Anaesthetic CG meeting for discussion and update on reporting system	Attended Anaesthetic Clinical Governance meeting 14th May and updated attendees on reporting system		1/5/15	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list): e-mail confirmation + Governance Gazette + Leaflet + CG meeting minutes				
Assurance statement :				
This compliance action has been completed				
Areas of concern for escalation:				
None				

Compliance action 17				CA17
Issue: *There was a lack of engagement and cohesive approach to clinical governance. Mortality and morbidity reviews were not robust, not all deaths were discussed and there was no available documentation to support discussions.*				
Lead: *Paul Sigston, Medical Director*		**Operational Lead:** *Jenny Davidson, Assc Director Governance, Quality and Patient Safety*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Full review and collaborative process involving all stakeholders for developing and implementing a cohesive and comprehensive clinical governance system from ward to board	Draft CG strategy commenced. External consultant started Governance review in April 2015 and is reviewing current governance arrangements and will produce options /recommendations for improvements	1. CG strategy including clear CG process from ward to board 2. M&M review documentation of full review process and evidence of clear discussions and shared learning 3. Update outline and attendance	1/9/15	
2. Development of a MTW Clinical Governance Strategy	Will commence alongside review process above		1/7/15	
3. Mortality and morbidity review process to be reviewed in collaboration with stakeholders and developed with exploration of further use of technology and clinical governance processes to improve rigor, transparency and effectiveness	Initial review undertaken and areas identified to improve the process and flow of information. Initial meeting with health informatics to ascertain how IT can assist supporting the process.		1/8/15	
4. Update for staff involved at directorate and Trust level on their role in the mortality & morbidity review process	Will commence once review completed and new system in place		1/10/15	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list): none				
Assurance statement :				
This action plan is running to time at present				
Areas of concern for escalation:				
None at present				

Compliance action 18				CA18
Issue: *The arrangement for the management and administration of topical anaesthetics was ineffective.*				
Lead: *Hamudi Kisat, Clinical Director*		**Operational Lead:** *Jackie Tyler, Matron*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Standard Operating Procedure for the administration of topical anaesthetics for children to be developed and implemented	Completed	1. SOP for children's services. 2. Audit of prescription charts. 3. Training records of staff undertaking PGD training	1/5/15	
2. Topical anaesthetics for children prescribed in all areas of the Trust	Audit to be undertaken to monitor compliance		1/6/15	
3. A number of key staff to undertake PGD training to facilitate appropriate timeliness of prescribing.	Training commenced for staff across both hospital sites		1/7/15	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list):				
Assurance statement :				
The actions for the management and administration of topical anaesthetic are nearly complete. The training of the majority of senior staff to use PGD's will take by the end of May.				
Areas of concern for escalation:				
None				

Should do actions

The following provides an update on 'should do' actions that are either due now or within the next 4 weeks.

REF	Service or Directorate	Issue Identified	Action/s	Operational leadership	Date to be completed	Evidence Required	Outcome/success criteria	**Summary update**
M10	Corporate	Develop robust arrangements to ensure that agency staff have the necessary competency before administering intravenous medicines in medical care services.	1. Add to agency booking checklist 2. Amend local induction checklist to include declaration by both manager and staff member 3. Communication to agencies that this now forms part of the Trust checklist	Richard Hayden, Deputy Director of Workforce / John Kennedy, Deputy Chief Nurse	1. 1/5/15 2. 1/5/15 3. 1/5/15	1. Booking form 2. Local induction checklist 3. Local audit findings	All agency staff that administer intravenous medicines are competent and have signed to confirm	**1. Agency booking checklist contains requirement** **2. Local induction checklist now includes declaration by both manager and staff member** **3. Agencies using checklist** **4. New contract in place from 1 June 15 with clearer reference to requirements**
M18	Corporate	Ensure that patients have access to appropriate interpreting services when required.	1. Survey of current service satisfaction via service leads and members of the patient experience committee (before and after any service change) 3. Identification of service users who can be invited to become involved in the evaluation of service needs in terms of the interpretation service 4. Engage assistance and involvement from Healthwatch	Jenny Davidson, Assc Director Gov, Quality and Pt Safety	1. 1/5/15 & 1/10/15 3. 1/5/15	1. Service leads survey results 2. Review report and outcome from tender process. 3. Service user group communications	1. Perceived improved service via survey 2. improved interpretation service as per continuous audit of performance reports 3. Service user group set up and effective at engaging in improvements	**Survey completed relating to service needs. Meeting with Healthwatch arranged that will facilitate the identification of service user groups**

TW49	Corporate	Have clarity about the definition of what constitutes a Serious Incident Requiring Investigation (SIRI) or Never Event in relation to the retained swabs.	1. Staff leaflet on including incident reporting process and what constitutes an SI and Never event to be produced in collaboration with staff and distributed to existing staff and new starters at induction. 2. Review of SI policy and ensure clarity.	Jenny Davidson, Assc Director Gov, Quality and Pt Safety	1. 1/5/15 2. 1/5/15	1. Staff leaflet and SI policy 2. Intranet & Website 3. Education / update program and attendance 4. Newsletter article	Staff can articulate about the definition of what constitutes a Serious Incident (SI) or Never Event. In areas where swabs are used this will include in relation to the retained swabs	**Staff leaflet completed. SI policy under revision and will be completed ready for consultation June 2015**
TW28	Emergency and Medical Services	Make appropriate arrangements for recording and storing patients' own medicines in the CDU to minimise the risk of medicine misuse.	1. Development of Standard Operating Procedure in relation to arrangements for recording and storing pateints own medicines in the CDU 4. Use of checklist to ensure no drugs remain in CDU following transfer or discharge of patient	Claire Hughes, Matron A&E	1. 1/5/15 4. 1/5/15	1. Appropriate equipment in place to safely store patients' own drugs 2. Evidence of checklists completed to ensure no drugs remain on CDU following transfer or discharge of patient 3. SOP	No patient safety incidents relating to mismanagement of patients' own drugs in CDU	**Individual drugs cupboards purchased for both CDU's - awaiting delivery at TWH and installation at MH**

M26	Emergency and Medical Services	Reduce delays for clinics and reduce patient waiting times.	1. Identify clinics in which there are high levels of DNA's , delays and waiting times.	Margaret Dalziel, Assc. Dir Operations	1. 1/5/15	1. Report on review of clinics DNA and templates 2. Appropriate booking of all clinic profiles 3.implementation of revised booking / reminder system 4. Feedback from Healthwatch	Reduced waiting times and delays	**Full scope of medical outpatients clinic structures and waiting times undertaken. In discussion with clinicians on clinic profile. To undertake an audit of waiting times in partnership with Healthwatch.**
M14	Emergency and Medical Services	Ensure within medical care services that patients' clinical records used in ward areas are stored securely.	2. Reinforce good housekeeping in relation to ensuring patient records are replaced in the notes trolley after use in clinical areas. 3. Remind office based staff about the need to minimise patient records being kept in offices and ensure office is secured when empty 4. Discuss (and minute) at following forums: • Ward Manager meetings • Quality & Safety Directorate Board • Clinical Governance 1/2 days • CAU meetings	Akbar Soorma, Clinical Director Lynn Gray, ADN Emergency care	2. 1/5/15 3. 1/5/15 4. 1/5/15	Report on current practice Results of spot audits Evidence of communication with staff and minutes of meetings	Adhere to record keeping guidelines and maintain patient confidentiality	**Scoping exercise undertaken. Assurance that appropriate equipment is being used in all area given. Minuted at all departmental meetings. Matron checks in place. CSP undertaking spot audits to ensure compliance. Reviewed monthly at Directorate Quality & Safety Board.**

M16	Emergency and Medical Services	Review the ways in which staff working in medical care services can access current clinical guidance to ensure it is easily accessible for them to refer to.	1. All actions in conjunction with actions identified in M4. In addition: 2. Review of access and management of clinical guidance / protocols / documents	Donna Jarret, Director of Informatics Jenny Davidson Assc Dir, Gov, Quality, Patient Safety	2. 1/5/15	1. Report on review of current clinical guidance 2. Update on departments pages of intranet	Medical staff aware of where to find clinical guidelines	**Survey undertaken about staff access to clinical records. Data gathered about access across the organisation. Meetings arranged to consider document management service needs and option appraisal**
M3	Emergency and Medical Services	Make sure that a sufficient number of consultants are in post to provide the necessary cover for the ED	2. Advertise for 2 new substantive consultant posts (already approved)	Akbar Soorma, Clinical Director	2. 1/5/15	1. Consultant rota (planned and actual) showing necessary cover. 2. Confirmation of recruitment and start dates	Improved patient flow through ED by earlier senior intervention Sufficient number of consultants are in post to provide the necessary cover for the ED	**Consultant rotas changed from April to provide greater clinical presence and senior medical leadership. Interviewed and appointed one new consultant, other post has gone out again to advert.**

M&TW6	Emergency and Medical Services	Review the way complaints are managed in the ED to improve the response time for closing complaints	2. Implement a revised process 3. Communicate the revised process to all ED staff and the central complaints team	Claire Hughes, Matron A&E	2. 1/5/15 3. 1/5/15	1. Documentation of agreed process and timeframes 2. Evidence of communication with staff 3. Audit of compliance with agreed process and timeframes 4. Minutes from monthly directorate clinical governance meeting and Standards Committee	Service delivered meets patients expectations All complaints responded to within 25 days	**Complaints structure within Directorate reviewed and plan to implement from mid - April. Monitoring of complaint management undertaken at monthly Directorate Quality & Safety Board.**
M9	Emergency and Medical Services	Ensure that medical care services comply with its infection prevention and control policies.	3. Audit local practice against infection prevention and control policies + actions developed where not compliant 3. Ensure IPPC is a standing agenda item at Directorate Clinical Governance meetings	Lynn Gray, ADN Emergency Care	3. 1/5/15 4. 1/5/15	1. Agenda and Minutes of ICC, Directorate Clinical Governance & Link Nurse Forums 2. Local audit + action plans where not complaint	IPPC rates below Trust trajectory and show evidence of continual reduction	**Review of IPCC prevalence at Directorate Quality & Safety Board. Actions taken for areas falling below expected standards of performance. Increased audits undertaken until performance at satisfactory level.**

M19	Emergency and Medical Services	Ensure that the directorate of specialty and elderly medicine reviews its capacity in medical care services to ensure capacity is sufficient to meet demand, including the provision of single rooms.	1. Corporate review of demand and capacity requirements for 15/16 and beyond, with recommendations / plan 2. Review of operational Surge Plans to support management of peaks in demand, particularly over Bank Holiday periods, with recommendations / plan	Margaret Dalziel, Assc. Dir Operations Lynn Gray, ADN Emergency Care	1. 1/5/15 2. 1/5/15	1. Report on corporate demand and capacity review submitted to TME (+ minutes from meeting) 2. Report on Surge plans submitted to TME (+minutes from meeting)	Patients admitted under the care of Emergency & Medical Services are cared for within the designated bed base and in the most appropriate ward for their condition.	**Bed modelling exercise completed. New facility planned for TWH. Programme structure in place to develop options and deliver additional capacity early 2016.**
TW27	Emergency and Medical Services	Ensure the protocol for monitoring patients at risk is embedded and used effectively to make sure patients are escalated in a timely manner if their condition deteriorates.	1. Implement teaching for all relevant staff regarding use of PAR scores. 2. Ensure staff are aware of the relevant protocol for monitoring patients at risk + timely escalation communicated through team meetings and electronic reminders 3. Introduction of new cas card with the PAR scores on them.	Lynn Gray, ADN Emergency Care	1. 1/5/15 2. 1/5/15 3. 1/5/15	1. Audit showing compliance with observations recorded and escalated appropriately as needed 2. Education attendance lists 3. communication with staff 4. new CAS card 5. outline of new education programme	Deteriorating patients identified, escalated and treated without delay	**A&E documentation reviewed and changed to include PAR scoring. Roll-out included a teaching package for all staff. Audit to be undertaken in June.**

TW29	Emergency and Medical Services	Respond to the outcome of their own audits and CEM audits to improve outcomes for patients using the service.	2. Ensure results presented and discussed at Directorate Clinical Governance meetings. 4. Specifically regarding the last CEM audit round – Symphony used to highlight high-risk patient groups for senior review and increased consultant cover will improve compliance. 5. Weekly review of pain scores and safeguarding questionnaires results by Clinical Leads and Clinical Director with performance issues addressed where necessary and extra support provided for individuals where required	Akbar Soorma, Clinical Director	2. 1/5/15 4. 1/5/15 5. 1/5/15	1. Communication to Clinical leads on their responsibilities and expectations on response / actions 2. Minutes of Directorate Clinical Governance Meetings with evidence of completed action plans and improvements in further audits 3. Weekly review documentation	Improved response to own audits and CEM audits to improve outcomes for patients	**Clinical Leads are taking this responsibility and have devised a new Consultant rota to ensure better Consultant presence on the shop floor from 6 weeks ago.**

TW30	Emergency and Medical Services	Review the management of patient flow in the ED to improve the number of patients who are treated and admitted or discharged within timescales which meet national targets.	1. Undertake a diagnostic review to understand where delays are currently occurring. 2. Agree actions to improve these areas. 3. Clarify roles and responsibilities for all staff involved in patient flows within ED.	Claire Hughes, Matron A&E Emma Yales, General Manager	1. 1/5/15 2. 1/5/15 3. 1/5/15	1. Report on diagnostic review and action plan 2. Communication about clear roles and responsibilities of all staff 3. Sustained improvement seen in 4 Hour Access Target 4. Feedback reports from Healthwatch + response and actions	Improved patient care and experience Management of patient flow in the ED in relation to patients who are treated and admitted or discharged within timescales which meet national targets	**An audit of high risk patient groups and the impact on new ways of working will be carried out shortly in the next4-6 weeks.**
TW32	Emergency and Medical Services	Ensure there is strategic oversight and plan for driving improvement.	1. Review ED Strategy for 2015-2017 2. Ensure strategy is developed in collaboration with all relevant stakeholders including a multidisciplinary approach	Akbar Soorma, Clinical Director Cliff Evans Consultant Nurse	1. 1/5/15 2. 1/5/15	1. Documented ED Strategy in place including evidence of consultation with multidisciplinary staff 2. Evidence of communication of strategy to all relevant staff	Continuous and sustained improvement in all ED key performance areas	**Pain scores and safety questionnaires is carried out and individual performance issues addressed on a weekly basis.**

TW34	Emergency and Medical Services	On the Medical Assessment unit the trust should ensure that point of care blood glucose monitoring equipment is checked. It should also consider how this checking should be managed to be integrated as part of an overall policy that forms part of a pathology quality assurance system.	2. Document daily checking of current blood glucose monitors in all ward areas.	Lynn Gray, ADN Emergency Care	2. 1/5/15	1. Business case and then procurement of BGM 2. Daily checking forms audit report + action log 3. Pathology Related Equipment Policy	Glucose Monitor equipment checked Minimised risk of inaccurate blood glucose readings being acted on	**Audit undertaken by junior doctors to compare results from near patient testing and lab. Results showed there was a clinically insignificant variation. Procurement of new blood glucose monitors is in progress.**
TW40	Emergency and Medical Services	Review the process for the management of patients presenting with febrile neutropenia to ensure they are managed in a timely and effective manner	1. Implement Rapid Assessment Treatment (RAT) process to identify patients early within their pathway.	Cliff Evans, Consultant Nurse	1. 1/5/15	1. Documented new pathway 2. Education update with attendance list 3. Audit results	Febrile neutropeanic patients are identified within first 30 minutes and put on the appropriate pathway	**Reviewing sepsis pathway and documentation. Audit of current provision undertaken in response to this. Screening process being adapted as a result. PGD written for nursing staff to enable commencement of IV antibiotics. Relaunch of sepsis screening pathway commenced including teaching for nursing and medical staff.**