CQC Quality Improvement Plan

Assurance Report JULY 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 actions. The second section presents progress of the 'should do' actions due this month.

On 6th July a group of stakeholders including Clinical Commissioning Group representatives, Healthwatch representatives and MTW representatives undertook an assurance review to 'test' progress in practice. This assurance review was hugely successful and provided a good level of assurance. The highlighted the need for greater communication and bedding of actions with front line clinical staff in terms of standards and expectations.

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. The CQC visited Maidstone hospital on 30th June to review evidence submitted in practice and the report is awaited.

Compliance actions – Paediatrics

The agreement and implementation of a suitable Trust-wide paediatric early warning system (PEWS) has been agreed and new charts are being printed. The prescription of topical anaesthetics for children has been tested in practice with evidence of good compliance both in A&E and inpatient wards. Training for PGD is well underway.

The Clinical Director for Paediatrics attended Surgical Clinical Governance meeting to discuss the new Standard Operating Procedure and other key documents related to the management of children form the Royal College of Surgeons.

Compliance actions – Critical care

Continued progress has been made in addressing the compliance actions against Critical Care, with a fully compliant intensivist rota expected September 2015, recruitment to Consultant posts continues There are continued pressures in meeting capacity demands but improvements seen in practice and incidents are monitored closely to ensure lessons can be learnt. Attendance at site meetings highlights issues and ensures follow up on a named patient basis.

Compliance Action – Process for incident reporting

Work continues on this compliance action with the new patient safety information leaflet for staff in the process of being distributed. There has been good progress with improving incident reporting process, with a more streamlined reporting form and the development of a DATIX app being added to the i-pads in the clinical areas, making reporting considerably faster and more accessible.

Compliance Action – Clinical Decision Unit (CDU)

CDU is now single sex, with good staff awareness of the standards expected.

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.

There is an element of judgement on the RAGB rating, based on the update and evidence provided and discussions.

The table below provides a summary of any issues arising.

KEY to progress rating (RAGB rating)

	Blue	Fully Assured
	Amber	Not running to time and / or more assurance required
	Green	Running to time, in progress / not running to time but sufficient assurance of progress
	Red	Not assured / actions not delivering required outcome

	Operational lead	Progress rating	Issues / Comments
Enforcement Notice – Water testing	Jeanette Rooke, Director of Estate & Facilities		Awaiting report form the CQC following on site review on 30th June 2015
CA 1 - Paediatric Early Warning Scoring (PEWS) system	Jackie Tyler, Matron Children Services		Identified need to have single trust PEWS system in place (both inpatient and emergency department). Good progress being made, however PEWS charts still not in place (currently in printing)
CA 2 – ICU weekend cover	Daniel Gaughan General Manager, Critical Care		Continued good progress with expected full compliance by September 2015. 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		This has been longer than anticipated due to multi department / specialist involvement in development and consultation of new operational policy (due to be ratified August 2015)
CA 5 – ICU delayed	Jacqui Slingsby Matron, Critical		

discharges	Care Directorate		
CA 6 – ICU overnight discharges	Jacqui Slingsby Matron, Critical Care Directorate		There were 0 at Maidstone and 4 at TWH in June. This is an improvement from May (3 at Maidstone, 5 at TWH). Plan in place to create additional capacity at TWH. Amber less than 5. Green less than 3.
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		All actions 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		All actions completed
CA 11 – Medical records	Wilson Bolsover Deputy Medical Director		Audit still outstanding, but plan in place
CA 12 – Security staff	John Sinclair Head of Quality, Safety, Fire and Security		All actions completed
CA 13 – Incident reporting	Jenny Davidson Associate Director of Governance, Patient Safety and Quality		Leaflet distribution continues
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 clinical governance	Jenny Davidson Associate Director of Governance, Patient Safety and Quality		None raised
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)	Visit to Brighton completed by Ward Manager and Paediatric ED sister to look at PEWs in action in different areas Meeting with ED matron, nurse consultant took place on 16th June with draft paperwork Amendments and changes agreed PEWS charts agreed at Directorate meeting on 26th June 2015 Documentation sent to printers for modifications on 2nd July	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 communication via meetings	30/6/15	
2. Escalation protocol reviewed alongside the PEWS chart review	Escalation protocol on back of PEWs charts.			
3. Once agreed, PEWS chart and escalation protocol implemented across Children's services directorate via teaching sessions, ward level meetings, A&E and Childrens services Clinical Governance meeting	To train staff and pilot new PEWs charts through July for implementation 1st August			
PHASE 2 Electronic solution (Nervecentre) for PEWS and escalation implemented (brought forward within existing IT plan). NB excludes paediatric A&E		6. Compliance audit from Nervecenter	31/12/15	
Action Plan running to time: **NO -** Delay due to change of PEWs charts- required as need to be used in ED, ambulatory and inpatient areas. Previous charts not suitable for ED.				
Evidence submitted to support update (list): Draft PEWS charts, awaiting minutes from Paediatric Directorate Meeting				
Assurance statement :				
The new PEWs charts will be utilised across all areas for children aged 0-16years				
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 and monitored on electronic rota	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	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		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	Reviewed, this will be implemented in September 2015.		3a. 31/3/15 3b. 1/10/15	
4. Business case for additional intensivists developed and considered	Agreed at TME June 2015		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 in July		1/4/16	
Action Plan: running to time				
Evidence submitted to support update (list): Intensivist rota, Risk assessment				
Assurance statement :				
Business case agreed at June TME recruitment process on going				
Areas of concern for escalation:				
Inability to recruit suitably qualified intensivists. This will require close monitoring and action plan if recruitment process is not successful				
Assurance review feedback (visit 6th July):				
Mainly assured that progress made as described above. Ward round evidence seen and staff aware of intentions of the 1:8 complaint rota to start in September.				

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 New complaint 1-8 rota to be implemented in September 2015	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	Please refer to summary in CA2		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 implementation September 2015				
Areas of concern for escalation:				
Potential risk of inability to recruit suitable intensivists				
Assurance review feedback (visit 6th July):				
Mainly assured that progress made as described above. 2 consultants are more than 30minutes from site, however this will be resolved with the new 1:8 rota to be implemented in September. Assurance of change within department from staff interviewed.				

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: *Greg Lawton, Clinical Director*		**Operational Lead:** *Jacqui Slingsby, Matron & Lynn Gray, ADN emergency services*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Consider option of ring-fencing ITU bed for admission	Discussed at Trust Management Executive June 15 This has not happened consistently due to ICU bed demand; consideration is given on a daily basis at the site meetings where critical care capacity is available across the trust going into the night.	1. Minutes of TME meeting where ring-fencing 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.	20/5/15	
2. Standard Operating Procedure developed relating to ITU admissions	Operational Policy which incorporates admission policy reviewed and comments made. Agreed at Directorate level, out for wider trust consultation. Expected ratification in August 2015		29/6/15 New date: 31/8/15	
3. Review SOP for managing critically ill patients requiring ITU, when ITU capacity is full (for e.g. in recovery)	The SOP is part of the new operational policy which has now been distributed for comment and will be tabled at the next standards committee (August) for ratification.		31/8/ 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 are consultant to consultant and raised to both the Clinical site team and Matron/Shift leader in ICU. Clinical priorities 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, date revised				
Evidence submitted to support update (list): ICU Standard operational policy in draft form for consultation.				
Assurance statement :				
Areas of concern for escalation:				

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:** *Jacqui 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 which incorporates admission policy reviewed and comments made. Consultation complete at directorate level. Policy out for wider consultation with all critical care users. Expected ratification August 2015 at Standards Committee	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.	29/6/15 New Date: 31/8/15	
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. Trust operational plan in place to open an additional ward at TWH by Jan 2016 with the aim to ease patient flow across the trust.		30/5/15	
Action Plan running to time: No				
Evidence submitted to support update (list): Operational policy ICU, ICU dashboard, delayed discharges summary data				
Assurance statement :				
Areas of concern for escalation:				
Data for first quarter of D16 CQUIN will illustrate non compliance with requirement to discharge all patients identified as ward fit within 24 hours				

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:** *Jacqui 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 communications 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.	Core standards state: *'Discharge from Critical Care should occur between 07:00hrs and 21:59hrs' (2.12)* During June no patients were transferred out of hours Maidstone and 4 at Tunbridge Wells. This is an improvement from May (3 at Maidstone, 5 at Tunbridge Wells) 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. Trust operational plan in place to open an additional ward at TWH by Jan 2016 with the aim to ease patient flow across the trust.		29/6/15	
Action Plan running to time: **No**				
Evidence submitted to support update (list): ICU dashboard data, out of hours discharges. Site reports				
Assurance statement :				
Areas of concern for escalation:				
Continuing issues with patient flow across the trust impacting on ICU patient discharges and admissions.				

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	All Band 7 posts fully recruited to		1/9/15	
3. Implementation of a 24 hour 7 day out-reach service which will be fully integrated with critical care service	Consultation commenced on 1st June 2015 Staff meeting held with Q&A sheet to inform all staff Nearly all 1:1 meetings completed Draft rota still under consultation		1/10/15	
Action Plan running to time:				
Evidence submitted to support update (list): Copy of consultation letter Copy of Q&A sheet for staff				
Assurance statement :				
All staff have been fully briefed and are engaged in the process.				
Areas of concern for escalation:				
None at present				

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:** *Jacqui 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 facilities 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.		1/4/15	
Action Plan running to time:		**Yes**		
Evidence submitted to support update (list):				
Assurance statement :				
Photographs: Submitted with April update All areas commissioned. Executive walk round at Maidstone – Avey Bhatia & Steve Tinton 13/4/15 at Tunbridge Wells – Paul Sigston 14/4/15 Reviewed and seen on 6th July internal review – fully compliant				
Areas of concern for escalation:				

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 & John Kennedy, Deputy Chief Nurse*			
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Appoint a dedicated lead for Equality and Diversity for Trust	Interim E&D Lead appointed April 2015 Business Care for substantive post holder being finalised and will be submitted for July 2015 IAG Chief Nurse appointed as Board Lead 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	April – 2015 – E&D training 89% compliant against 85% target Benchmarking and intelligence from partner Trust to inform awareness programme and roll out plan		1/10/15	
3. Review and develop new E&D strategy for organisation, in collaboration with MTW staff and partner organisations	Draft WF strategy approved June 2015. E&D priorities included & supported by implementation plan for approval by September 2015 Workforce Committee BME Forum met 22 June 2015		1/9/15	
4. Ensure current process for accessing translation services is communicated to all staff	Staff Communication circulated January 2015 – plan to recirculate July 2015		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	Working in partnership with Southern Health, Portsmouth NHS FT and Leicestershire Partnership Trust.		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	Under assessment with intention to commission external support by 31 July. Priority Plan to be finalised linked to EDS2 grading plan		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	Under assessment with patient and Carers Groups. Healthwatch will also act as final approver for EDS2 Meeting to be arranged with Healthwatch July 2015		1/10/15	
8. Ensure appropriate organisational governance with assurance to Trust Board in relation to Equality and Diversity	Briefing on E&D plans, EDS2 and Leadership and Governance plan will be submitted to Executive team by 30 June		1/9/15	
Action Plan running to time:				
Evidence submitted to support update (list):				
Assurance statement :				
Areas of concern for escalation:				

Compliance action 10				CA10
Issue: *Dignity and privacy of patients was not being met in the Clinical Decisions Unit (CDU)*				
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)	CDU became single sexed (female) from 8th June with 2 rooms on MAU being used if required for men. SOP circulated. This has been maintained to date.	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	Long term plan has been discussed within the Directorate and two options are being scoped (AAU and MAU) to find an alternative area for CDU capacity from January 2016 once the new ward opens. Both options provide DSSA compliance.		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	CDU capacity and demand continues to be discussed at each site meeting. Site report reflect s any variance from SOP over the last 24 hours (none have occurred to date).		1/4/15	
4. To link in with Trust wide work around patient flow and action TW30	Review of pathways to support the A&E flow has occurred as a result of AAU opening in May.		30/5/15	
Action Plan running to time: YES				
Evidence submitted to support update (list):				
Assurance statement :				
CDU single sex (all female). All staff aware of standard operating procedure and mandatory single sex CDU status.				
Areas of concern for escalation:				

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) Currently under discussion with clinical directors b) This has been considered and will re-considered if the audit shows this may be of benefit c) Audit will need to include the availability and completeness of the case records. Agreement with Audit team to undertake this audit over coming 6 weeks	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 new date 1/9/15	
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 new date 1/10/15	
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.	Completed and closed	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	18/5/15	
2. All contractors to attend the Trust approved and agreed Induction Training and attend the Trust mandatory training	Completed – evidence in the security SLA minutes		1/4/15 New date: 1/7/15	
3. Contractors to be included on the Training Needs Analysis document outlining all requirements, frequency and levels	Completed and closed		1/5/15	
4. Review compliance with all training requirements against existing security team	Completed. Security contractor has 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.	Completed – evidence in the security SLA minutes		1/4/15 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 security staff booked on sessions		1/8/15	
Action Plan running to time:				
Evidence submitted to support update (list):				
Assurance statement :				
Completed and fully assured				
Areas of concern for escalation:				
Request for all our security officers to be put on the L&D mandatory training system.				

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 Distribution continues following external printing of leaflet	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 Distribution will take 2-3months but is underway	
2. Governance page to be developed on the intranet and MTW website with clear signposting to Incident Reporting section	Allocated lead for this work. Intranet completed. 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	Datix upgrade completed. Datix review group established. Reporting page streamlined and quicker. DATIX app now being loaded on the new Ipad's to be used in clinical practice		1/6/15 New date for completion of all actions: 1/8/15	
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 new patient safety manager secondment due to commence in September 15.		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.	Monthly articles in Governance Gazette		Monthly	
Action Plan running to time: ***Yes***				
Evidence submitted to support update (list):				
Assurance statement :				
This action plan is well underway with good progress. Some unexpected delays in Datix upgrade but now resolved				
Areas of concern for escalation:				
Patient Safety Manager due to commence post September 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	Dr Kisat attended the surgical directorate in the clinical governance meeting on 16th June and presented 2 papers 1) Standard for Surgery in paediatrics 2013 2) Commissioning guideline for emergency appendicectomy RCS 2015	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	Local guideline reviewed at Paediatric Directorate meeting 26th June 2015 – awaiting comments also circulated by email to Fazal Hassan and allied surgical speciality.		1/6/15	
3. Implementation of the SOP into routine daily practice	Patients admitted to Inpatient Ward now shared care between Paediatrics and Speciality Teams		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	External report expected end of July 2015		1/9/15	
Action Plan running to time: Yes				
Evidence submitted to support update (list):				
Assurance statement :				
Currently running to schedule – slight delay on formalising draft SOP due to meeting date				
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	On-going review and updating at Directorate meetings	1. Risk register shows children's section managed in a timely manner 2. Minutes of Directorate meeting / Clinical Governance meeting 3. Meeting agendas	1/5/15	
2. An update session for all senior nursing and medical staff on the purpose and process of the risk register	Staff updates on-going: new 'Risk Update' publication distributed		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):				
Assurance statement :				
On-going commitment continues within Directorate				
Areas of concern for escalation:				
None				

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. Assc. Director Quality Governance and Patient Safety attended Anaesthetic Clinical Governance meeting in May 2015 to discuss the Trust Incident reporting system in place and take questions.	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, but distribution continues		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 continue alongside review process above		1/7/15 New date: 1/10/15	
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	MTW mortality review process has been reviewed and strengthened with work continuing at Trust and directorate level. Quality 'Deep Dive' into current process. Mortality Review workshop hosted by Dr. Foster being attended by MD and CN to learn other Trusts approaches (7/7/15) Discussion underway with IT/ health informatics at MTW to implement IT based system NTDA to assess and provide supportive feedback in August		1/8/15	
4. Update for staff involved at directorate and Trust level on their role in the mortality & morbidity review process	Will follow on from action taken above.		1/10/15	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list): External consultant update on governance review at executive meeting. Minutes of Trust Mortality Review Group meeting				
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	Assessed in July 2015. Drug charts reviewed and topical anaesthetics prescribed. Evidence of good staff awareness.		1/6/15	
3. A number of key staff to undertake PGD training to facilitate appropriate timeliness of prescribing.	Training ongoing for Paediatric staff- all band 6 nurses rostered onto trust PGD study days until end of year to enable compliance Ward manager now compliant and able to assess staff competency Training continues		1/7/15	
Action Plan running to time: Yes				
Evidence submitted to support update (list):				
Assurance statement :				
This action plan is currently running to time				
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	Lead	Operational leadership	Date to be completed	Evidence Required	Outcome/success criteria	Summary Update
M12	Diagnostics Therapies and Pharmacy	Ensure that systems are in place to ensure that the system of digital locks used to secure medicines storage keys can be accessed only by authorised people.	3. Audit of digital locks to the medicines security audit	Sara Mumford, Clinical Director	Jim Reside, Chief Pharmacist John Kennedy, Deputy Chief Nurse	3. 1/7/15	1. Trust Medicines Policy updated 2. Audit of digital lock compliance with Medicines Policy added to medicines security audit criteria and checklist	1. Medicines Policy in place 2. Regular audit of security of medicines to include key pad access	1. Medicines Policy in place 2. Regular audit of security of medicines to include key pad access - new audit tool devised to include questions about digital locks on wards (copy attached). Trust wide audit being carried out in June/July with completion by early August 2015. Action plan to address deficiencies to follow from results.

TW35	Emergency and Medical Services	Develop systems to ensure the competence of medical staff is assessed for key procedures.	1. Identify a list of key procedures for all medical staff 2. Review SI's and complaints to identify any particular procedures that have caused harm to patients to support prioritisation of this work	Akbar Soorma, Clinical Director	Akbar Soorma, Clinical Director	1. 1/7/15 2. 1/7/15	1. List of key procedures produced 2. Copies of signed competency documents 3. Agreement between CD and Specialist medicine department lead on standardisation approach 4. Document outlining agreed standards and process for the assessment of competency for identified key procedures for all medical staff	No patient safety incidents caused by a lack of operator skill or knowledge Systems in place to ensure the competence of medical staff is assessed for key procedures.	Relevant medical staff undergo competency training for a variety of medical clinical procedures. Training sessions are signed off for competency in individual skills. Non-training grades have specific sessions which are directed at skill and knowledge development. Particular issues or developments are highlighted at clinical governance sessions.

M&TW2	Emergency and Medical Services	Make sure that medical staff complete training in safeguarding children at the level appropriate to their grade and job role (TW Specific for A&E)	2. Ensure all staff booked or have attended required training	Akbar Soorma, Clinical Director	Jo Howe, Lead Nurse for Children's Safeguarding	2. 1/7/15	1. Report on review of medical staff training (TNA) 2. Documentation to support attendance at training 3.Medical staff able to describe key elements of Child Protection	Appropriate actions taken to protect vulnerable children All staff appropriately trained in safeguarding of children	Appropriate level of training for medical staff is in place. Attendance levels are monitored and feedback at Quality and Safety meetings.
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.	4. Undertake monthly audits to monitor compliance. 5. Implementation of on-going Education programs for all relevant staff groups to ensure regular updates on PAR scoring.	Akbar Soorma, Clinical Director	Lynn Gray, ADN Emergency Care	4. 1/7/15 5. 1/7/15	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	Monthly audits in place at both sites. Statistics clearly displayed in both departments to highlight current improvements. Educational campaign in place. Individuals identified as not meeting the standard expected which is clearly identified within their appraisals will have the issue discussed with them and support put in place

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	3. Undertake audit to review impact.	Akbar Soorma, Clinical Director	Cliff Evans, Consultant Nurse	3. 1/7/15	1. Documented new pathway 2. Education update with attendance list 3. Audit results	Febrile neutropenic patients are identified within first 30 minutes and put on the appropriate pathway	Regular monthly audits in place. Required improvements / learning discussed with those involved. This standard features in the appraisal documents of all nursing staff. Education campaign in place and real life case studies highlighted to all staff.
TW46	Women's & Sexual Health	Review the current clinic provision to ensure that women who have recently miscarried or who are under review for ante-natal complications are seen in a separate area to children who are also awaiting their appointment.	2. Present options at Directorate Clinical Governance and agree on plan to address	Hilary Thomas , Interim Head of Midwifery	Hilary Thomas, interim Head of Midwifery	2. 1/7/15	1. Report on issue and implemented changes. 2. Minutes of directorate Clinical Governance meeting 2. Reviewed on walkabout by linked executive	Women to be able to wait in an area appropriate to their individual needs	Area designated and furniture in place. Quote being obtained for additional screen to display patient names linked to Kiosk so that patients can be called from this area.etc