# **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 6<sup>th</sup> 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 30<sup>th</sup> 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.

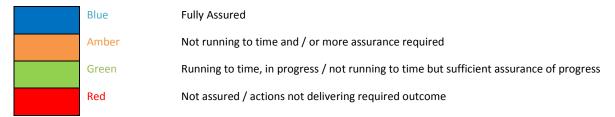
#### Status of plan

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)**



	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 30 <sup>th</sup> 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  CA 3 – ICU consultant	Daniel Gaughan General Manager, Critical Care  Daniel Gaughan General		Continued good progress with expected full compliance by September 2015. Risks assessed and mitigation in place in the meantime.
within 30mins	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
CA 5 – ICU delayed	Jacqui Slingsby Matron, Critical		ratified August 2015)

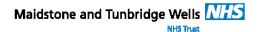
discharges	Care Directorate	
CA 6 – ICU overnight discharges	Jacqui Slingsby Matron, Critical Care Directorate	There were 0 at Maidstone and 4 at TWH in June. This is an improvement from May (3 at Maidstone, 5 at TWH). Plan in place to create additional capacity at TWH. Amber less than 5. Green less 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
<b>CA 10</b> – 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		Outcome/succe ss 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 (5) 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)(b).	Executive Lead: Glenn Douglas	Date compliance will be achieved by: January 2015	EN1	Estates and Facilities Management	months overdue at	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.	Jea nette 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



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	<b>Operational Lead:</b> Jackie Tyler, Matron
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Actions	, · · · · · · · · · · · · · · · · · · ·	Evidence required	Action	Rating
Actions	Monthly summary update on progress	Evidence required	completion date	Kuting
1. PEWS chart reviewed in	Visit to Brighton completed by Ward Manager	1. Validated PEWS in	30/6/15	
line with tertiary referral	and Paediatric ED sister to look at PEWs in	place.		
centres (Nottingham) or	action in different areas	2. Revised escalation		
PEWS from National Institute	Meeting with ED matron, nurse consultant took	protocol in place		
for Innovation (used in other	place on 16 <sup>th</sup> June with draft paperwork	3. Staff competent		
Trusts)	Amendments and changes agreed	and consistent in		
	PEWS charts agreed at Directorate meeting on	using PEWS and		
	26 <sup>th</sup> June 2015	escalation.		
	Documentation sent to printers for	4. 3 monthly audit		
	modifications on 2nd July	of compliance		
2. Escalation protocol	Escalation protocol on back of PEWs charts.	5. Evidence of		
reviewed alongside the PEWS		communication via		
chart review		meetings		
3. Once agreed, PEWS chart	To train staff and pilot new PEWs charts			
and escalation protocol	through July for implementation 1 <sup>st</sup> August			
implemented across				
Children's services directorate				
via teaching sessions, ward				
level meetings, A&E and				
Childrens services Clinical				
Governance meeting				
PHASE 2		6. Compliance audit	31/12/15	
Electronic solution		from Nervecenter		
(Nervecentre) for PEWS and				
escalation implemented				
(brought forward within				
existing IT plan). NB excludes				
paediatric A&E				

**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:



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	Oper	ational Lead: Daniel Gaug	han, GM	
Actions	Monthly summary update on progress		Evidence required	Action completion date	Rating
Morning week-end ward rounds on both units implemented	Implemented and monitored or electronic rota	n	Anaesthetic electronic     rota showing allocation of     intensivists at weekends to	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 8 compliant rota, implementati September 2015	nt a 1-	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	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 implement in September 2015.	nted	made 4. Audit of patients medical notes documenting weekend Consultant reviews	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 intensivi	ist		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 6<sup>th</sup> 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.



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.

<b>Lead:</b> Greg Lawton , Clinical Director			ational 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 Clinical Director	the	Report from Clinical     Director outlining each     Consultant's travel distance     and confirmation of each     Consultants ability to respond     within 30 minutes.     Any delays in responding to     be reported as incidents	31/5/15		
2. Risk assessment to be undertaken where travel times exceed 30mins	This has been completed to superiting the mitigation until new rota common in September 2015.	•	(DATIX) 3. Audit of patients medical notes documenting weekend Consultant reviews	31/5/15		
3. Ward round compliance actions in CA2	Please refer to summary in CA2	2	New complaint 1-8 rota to be implemented in September 2015	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 6<sup>th</sup> 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.



Lead: Greg Lawton,	Clinical Director	Operational Lea emergency services	<b>d:</b> Jacqui Slingsby, Matro	on & Lynn Gray, A	IDN
Actions	Monthly summary update on		Evidence required	Action completion date	Rating
1. Consider option of ring-fencing ITU bed for admission	Discussed at Trust Manageme This has not happened consist demand; consideration is give the site meetings where critica available across the trust going	ently due to ICU bed n on a daily basis at al care capacity is	ntly due to ICU bed meeting where ring- on a daily basis at fencing option discussed		
2. Standard Operating Procedure developed relating to ITU admissions	Operational Policy which incorpolicy reviewed and comment Directorate level, out for wide Expected ratification in August	s made. Agreed at r trust consultation.	admissions, transfers and discharges. SOP for managing critically ill patient	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 ope which has now been distribute will be tabled at the next stand (August) for ratification.	erational policy ed for comment and	nal policy comment and committee  3. Site report documentation 4. Monthly performance data 5. DATIX IR1		
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 meeti leader/matron in place. Associate Director responsible ITU capacity and demand is dismeeting and plans put in place to transfer out as appropriate. ITU referrals are consultant to raised to both the Clinical site Matron/Shift leader in ICU. Clinical priorities identified by intensivist	for the site ensures scussed at each site with clinical teams consultant and team and	completed for each patient who has a delayed admission to ITU due to inability to move wardable patients.	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 Critical care capacity within Tr transfer outside of organisatio National Emergency bed servio	ust reviewed before n.		1/1/15	
Action Plan running	to time: NO, date revised to support update (list): IC				



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

		Territory services	Action	Dating
Actions	Monthly summary update on progress	Evidence required	completion date	Rating
1. Standard Operating	Operational Policy which incorporates	1. SOP for ITU admissions,	29/6/15	
Procedure to be	admission policy reviewed and	transfers and discharges.		
developed relating to	comments made. Consultation	2. Site report documentation.	New Date:	
ITU discharges	complete at directorate level. Policy	3. Monthly performance data	31/8/15	
	out for wider consultation with all	4. DATIX incident report		
	critical care users. Expected ratification	completed for each patient		
	August 2015 at Standards Committee	who has a delayed discharge		
2. Transfers out of ITU	In place at site meetings	from ITU.	1/4/15	
to be followed up on a				
named patient basis at				
each site meeting				
3. To link in with Trust	Monthly delayed discharge		30/5/15	
wide work around	performance data captured on			
patient flow and	performance dashboard and within			
delayed discharges	monthly unit reports. Performance			
improvement plan	against milestones reported at			
developed in line with	monthly CQUIN board.			
D16 CQUIN and in				
collaboration with	Incident forms completed for each			
Chief Operating Officer	delay, clinical site team identified as			
and Clinical Site	handlers.			
Management team				
	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.			

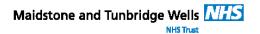
**Action Plan running to time:** No

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



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:

### Evidence submitted to support update (list):

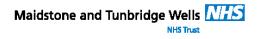
ICU dashboard data, out of hours discharges. Site reports

No

#### **Assurance statement:**

#### Areas of concern for escalation:

Continuing issues with patient flow across the trust impacting on ICU patient discharges and admissions.



Compliance action	า 7			CA7			
•	<b>Issue:</b> The outreach service does not comply with current guidelines (National Confidential Enquiry into						
Patient Outcome and D	Patient Outcome and Death (NCEPOD) (2011))						
Lead: Greg Lawton, C	Clinical Director	Opera	tional Lead: Siobhan	Callanan, ADN planned	care		
Actions	Monthly summary update on	progress	Evidence required	Action completion date	Rating		
1. Business Case	Approved		1. Rota showing 24	27/1/15			
approved			hour / 7day cover				
2. Recruitment to posts	All Band 7 posts fully recruited	to	2. Review of service	1/9/15			
3. Implementation of a	Consultation commenced on 1	<sup>it</sup> June	and performance	1/10/15			
24 hour 7 day out-	2015		data via Directorate				
reach service which will	Staff meeting held with Q&A sh	neet to	Clinical Governance				
be fully integrated with	inform all staff		meetings				
critical care service	Nearly all 1:1 meetings comple						
	Draft rota still under consultati	on					
Action Plan running	to time:						
Evidence submitted	to support update (list):						
Copy of consultation lette	er						
Copy of Q&A sheet for st	aff						
Assurance statemen	t:						
All staff have been for	ully briefed and are engage	d in the	process.				
Areas of concern for	escalation:						
None at present							

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 Lawto	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 TWI and contains a toilet within the shower room.  The staff toilet which is co-locate to the existing facility has been reassigned and designated as a patient toilet, with appropriate signage	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

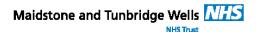
Reviewed and seen on 6<sup>th</sup> July internal review – fully compliant

### Areas of concern for escalation:



#### CA9 Compliance action 9 **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 **Operational Lead:** Richard Hayden, Deputy Director Human **Director Human Resources** Resources & John Kennedy, Deputy Chief Nurse Action Rating Actions Monthly summary update on **Evidence required** completion progress date 1. Appoint a dedicated lead for Equality Interim E&D Lead appointed April 2015 1. Substantive E&D 1/9/15 Business Care for substantive post holder Lead Appointed and Diversity for Trust being finalised and will be submitted for 2. Training records July 2015 IAG against E&D Chief Nurse appointed as Board Lead awareness May 2015 programme 2. Develop an E&D awareness April - 2015 - E&D training 89% 3. New E&D Strategy 1/10/15 4. Detailed action programme for all staff compliant against 85% target plan for Benchmarking and intelligence from improvements partner Trust to inform awareness 5. Evaluation of programme and roll out plan changes to service 3. Review and develop new E&D 1/9/15 Draft WF strategy approved June and feedback from strategy for organisation, in 2015. E&D priorities included & staff (staff survey), collaboration with MTW staff and supported by implementation plan patients, partner organisations for approval by September 2015 Healthwatch and community groups **Workforce Committee** (with actions BME Forum met 22 June 2015 developed and Staff Communication circulated January 1/2/15 4. Ensure current process for accessing monitored as translation services is communicated to 2015 - plan to recirculate July 2015 required) 1/6/15 5. Identify an existing NHS centre of Working in partnership with Southern excellence and buddy with them to Health, Portsmouth NHS FT and ensure best practice and learning Leicestershire Partnership Trust. implemented in a timely fashion 6. Conduct a comprehensive review of 1/4/16 Under assessment with intention to all existing Trust practices in relation to commission external support by 31 E&D requirements - for example July. Priority Plan to be finalised information, translation, clinical linked to EDS2 grading plan practices, food, facilities 7. Develop links with local support 1/10/15 Under assessment with patient and groups and communities to engage Carers Groups. Healthwatch will also them in the improvement plan for the act as final approver for EDS2 Trust with assistance from Healthwatch Meeting to be arranged with Healthwatch July 2015 1/9/15 8. Ensure appropriate organisational Briefing on E&D plans, EDS2 and governance with assurance to Trust Leadership and Governance plan will Board in relation to Equality and be submitted to Executive team by Diversity 30 June **Action Plan running to time:** Evidence submitted to support update (list): **Assurance statement:** Areas of concern for escalation:

Issue: Dignity and privacy of patients was not being met in the Clinical Decisions Unit (CDU)	Compliance action	n 10			(	CA10				
Actions  Monthly summary update on progress  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)  2. Agree preferred option and implement ward opens. Both 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.  3. Each patient to be tracked and discussed at each site meeting to ensure timeframes met and plan for discharge / transfer in place  4. To link in with Trust wide work around patient flow and action TW30  Action Plan running to time:  Monthly summary update (list):  CDU sapacity 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 as a result of AAU opening in May.  TW30  Action Plan running to time:  YES  Evidence submitted to support update (list):  Assurance statement:  CDU single sex (2DU status.	Issue: Dignity and privacy of patients was not being met in the Clinical Decisions Unit (CDU)									
1. Options appraisal for addressing existing dignity and privacy lissues in CDU (2 main options are Option 1: changing function of CDU or Option 2: provision of toilet facilities)  2. Agree preferred option and implement  3. Each patient to be tracked and discussed at each site meeting to ensure timeframes met and pand pro discharge / transfer in place  4. To link in with Trust wide work around patient find and action TW30  Action Plan running to time:  YES  CDU serds single sexed (female) from 8iii June with 2 rooms on MAU paper 2. Changes to CDU apaper 2. Changes to CDU environment reviewed by link executives and reported at Standards Committee  3. Site report of 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.  CDU capacity from 8iii June with 2 rooms on MAU being death of the quite work around past for discharge / transfer in place  4. To link in with Trust wide work around Patient flow and action TW30  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 singlesex CDU status.	Lead: Akbar Soorma, Clinical Director  Operational Lead: Lynn Gray, ADN emergency									
addressing existing dignity and privacy sissues in CDU (2 main options are Option 1: changing function of CDU or Option 2: provision of toilet facilities)  2. Agree preferred option and implement with 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.  3. Each patient to be tracked and discussed at each site meeting to ensure timeframes met and plan for discharge / transfer in place 4. To link in with Trust wide work around patient flow and action TW30  Action Plan running to time:  From 8 <sup>th</sup> June with 2 rooms on MAU being used if required for men. SOP over the last 24 hours (none have occurred as a result of AAU opening in May.  TW30  From 8 <sup>th</sup> June with 2 rooms on MAU being used if required for men. SOP over plan has been discussed at Exchanges to CDU committee  Standards Committee  3. Site report documentation  1/4/16 Option 1: 1/4/16 Option 1: 1/4/15 Option 1: 1/4/15  1/4/15  1/4/15  1/4/15  1/4/15  1/4/15  1/4/15  30/5/15  ASE Evidence submitted to support update (list):  Assurance statement:  CDU single sex (all female). All staff aware of standard operating procedure and mandatory singlesex CDU status.	Actions	Monthly summary update on	progress	Evidence required	completion	Rating				
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.  3. Each patient to be tracked and discussed at each site meeting to ensure timeframes met and plan for discharge / transfer in place  4. To link in with Trust wide work around patient flow and action TW30  Action Plan running to time:  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.	addressing existing dignity and privacy issues in CDU (2 main options are Option 1: changing function of CDU or Option 2: provision of toilet	from 8 <sup>th</sup> June with 2 rooms on being used if required for men SOP circulated. This has been	MAU	paper 2. Changes to CDU environment reviewed by link executives and reported at Standards	1/5/15					
tracked and discussed at each site meeting.  at each site meeting to ensure timeframes met and plan for discharge / transfer in place  4. To link in with Trust wide work around patient flow and action TW30  Action Plan running to time:  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.	2. Agree preferred	within the Directorate and two are being scoped (AAU and MA find an alternative area for CDI capacity from January 2016 on new ward opens. Both options		1/4/16 Option 2:						
4. To link in with Trust wide work around A&E flow has occurred as a result of AAU opening in May.  TW30  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.	tracked and discussed at each site meeting to ensure timeframes met and plan for discharge /	CDU capacity and demand con to be discussed at each site me Site report reflect s any variand SOP over the last 24 hours (no	eting. ce from		1/4/15					
Evidence submitted to support update (list):  Assurance statement:  CDU single sex (all female). All staff aware of standard operating procedure and mandatory singl sex CDU status.	4. To link in with Trust wide work around patient flow and action	A&E flow has occurred as a res			30/5/15					
Assurance statement: CDU single sex (all female). All staff aware of standard operating procedure and mandatory singl sex CDU status.	Action Plan running	to time: YES								
Assurance statement: CDU single sex (all female). All staff aware of standard operating procedure and mandatory singl sex CDU status.	Evidence submitted	to support update (list):								
sex CDU status.	Assurance statemen	t:								
Areas of concern for escalation:	CDU single sex (all female). All staff aware of standard operating procedure and mandatory single sex CDU status.									
	Areas of concern for escalation:									



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	Rating
1. Reinforce requirements of	a) Currently under discussion with clinical	1. Minutes of	date 1a. 1/6/15	
Health Care Record keeping	directors	Directorate	1b. 1/6/15	
amongst multidisciplinary staff,	b) This has been considered and will re-	Clinical	1c. 1/6/15	
including timely recording of	considered if the audit shows this may be	Governance	new date	
actions undertaken by:	of benefit	meetings  2. Staff audit	1/9/15	
1a. Record Keeping champion	c) Audit will need to include the	pilot		
for department who will be a	availability and completeness of the case	3. Record		
source of information and	records. Agreement with Audit team to	keeping		
support for record keeping	undertake this audit over coming 6 weeks	champion		
standards  1b. Investigate the possibility		program and list		
of providing a name stamp for		4. Report on		
staff		name stamps		
1c. Staff involvement in record		for staff and		
keeping audit		recommendat ions		
2. Review induction programme	a) Induction for trainees includes legibility	5. Induction	1/5/15	
for new Doctors to ensure	of notes (15.4.15)	programme		
adequate training provided.	b) Clinical Tutors asked to add in	for new		
	requirement to avoid loose papers	doctors 6. Report		
	(7.5.15)	from task and		
	c) College tutors to be prompted about induction for non-training grades once (b)	finish group		
	completed.	on records		
3. Multidisciplinary Task and	a) Discussed at CD Board (6.5.15). No		1/6/15	
Finish group (sub-group of	perceived need to change the case note			
health records committee) to	records ahead of implementation of			
review current notes with fresh	electronic records.			
eyes and consider where				
improvements can be made  4. Record keeping audit to be	Not commonced as yet		1/9/15 new	
included in case reviews at	Not commenced as yet		date	
Directorate CG Meetings			1/10/15	
z cotorate co meetings		l	_, _0, _0	

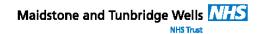
Action Plan running to time: Yes

**Evidence submitted to support update (list):** 

**Assurance statement:** 

Work has commenced and is in progress

Areas of concern for escalation:



#### 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 Operational Lead: John Sinclair, Head of Quality, Safety, **Facilities** Fire & Security Action Rating Actions Monthly summary update on progress Evidence completion required date 18/5/15 Completed and closed 1. Provide documentation outlining 1. Agreed the joint partnership with our documentation contractor in regards to the on joint provision of training. partnership 2. All contractors to attend the Completed – evidence in the security SLA arrangements 1/4/15 2. Induction Trust approved and agreed minutes Attendance / Induction Training and attend the New date: Trust mandatory training compliance 1/7/15 report on all 3. Contractors to be included on Completed and closed 1/5/15 existing security the Training Needs Analysis staff to Security document outlining all Group requirements, frequency and levels 3. TNA document 4. Review compliance with all Completed. Security contractor has 100% 1/5/15 4. Report on training requirements against compliance rate in accordance with BSIA training existing security team compliance to 5. The Security Manager to provide Completed - evidence in the security SLA 1/4/15 Security Group training logs for the SMART Risk minutes 5. Certificates of Assessment Training undertaken New date: training 1/7/15 through one to one sessions with 6. Certificates of all security officers. training 6. All current security staff to be All security staff booked on sessions 1/8/15 booked onto and attend Mental Health Awareness Training and dementia awareness training **Action Plan running to time:** Evidence submitted to support update (list): Assurance statement : Completed and fully assured

Request for all our security officers to be put on the L&D mandatory training system.

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 Action Rating Actions Monthly summary update Evidence required completion date on progress 1/5/15 1. Staff leaflet on Trust Quality and Risk Leaflet completed 1. Leaflet + audit of Policy, including incident reporting Distribution continues distribution and staff Distribution will process to be produced in following external printing engagement through take 2-3months collaboration with staff and distributed of leaflet survey but is underway to existing staff and new starters at 2. fully implemented induction intranet and web page Intranet 1/6/15 2. Governance page to be developed Allocated lead for this 3. Datix Staff survey + Website reporting figures / by on the intranet and MTW website with work. Intranet completed. 1/10/15 profession clear signposting to Incident Reporting Bolder reporting incident section button already changed on 4. Education presentation + staff intranet front page survey 1/6/15 3. Incident reporting process currently Datix upgrade completed. 5. Newsletter every under review, with full collaboration Datix review group with clinical staff, to improve reporting established. Reporting month New date for process and investigate possibility of page streamlined and completion of hosting reporting portal on mobile quicker. DATIX app now all actions: media being loaded on the new 1/8/15 Ipad's to be used in clinical 1/9/15 4. Education / update program on Identified within team and Governance, Quality and Patient Safety included in Governance team strategy, this work including incident reporting and learning lessons from incidents to be will be supported by new rolled out to all medical and nursing patient safety manager staff over next year secondment due to commence in September 5. Continue to publish articles on Monthly articles in Monthly **Governance Gazette Newsletter** Governance Gazette relating to incident reporting and learning lessons. Encourage staff to write their own articles for publication. Action Plan running to time: Yes

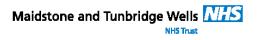
# Assurance statement :

This action plan is well underway with good progress. Some unexpected delays in Datix upgrade but now resolved

#### Areas of concern for escalation:

Evidence submitted to support update (list):

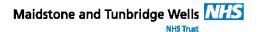
Patient Safety Manager due to commence post September 2015



Compliance action	14			CA14	
<b>Issue:</b> The clinical gove	ernance strategy within chi	ildren's servi	ces did not ensure ei	ngagement and involv	vement
with the surgical direct	orate				
<b>Lead:</b> Hamudi Kisat, Cl	inical Director & C	<b>Operational</b>	Lead: Hamudi Kisat	t, Clinical Director &	
Johnathan Appleby, Cli	nical Director Jo	ohnathan Ap	pleby, Clinical Direct	tor	
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  2. Standard Operating Procedure for care of children on surgical pathway on paediatric wards	Dr Kisat attended the surgic directorate in the clinical go meeting on 16 <sup>th</sup> June and propapers  1) Standard for Surgic paediatrics 2013 2) Commissioning go emergency appending RCS 2015  Local guideline reviewed at Directorate meeting 26 <sup>th</sup> June awaiting comments also circle email to Fazal Hassan and a surgical speciality.	gery in uideline for dicectomy  Paediatric ne 2015 – culated by	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	
3. Implementation of the SOP into routine daily practice	Patients admitted to Inpatie now shared care between P 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	External report expected en 2015	nd of July		1/9/15	
stakeholders					
Action Plan running	to time: Yes				
Evidence submitted	to support update (list):	<u> </u>			
Assurance statemen	t:				
Currently running to	schedule – slight delay o	on formalisi	ing draft SOP due t	o meeting date	
Areas of concern for					



Compliance action 15 CA15									
<b>Issue:</b> The children's directorate manner.	e risk register d	id not ensure that risks	are recorded and resol	lved in a timel	ly				
<b>Lead:</b> Hamudi Kisat, Clinical Dir	<b>Lead:</b> Hamudi Kisat, Clinical Director  Operational Lead: Karen Carter-Woods, Risk and Governance Manager								
Actions	Monthly sumn	nary update on progress	Evidence required	Action completion date	Rating				
1. A full review of the directorate risks	On-going revie Directorate me	w and updating at eetings	1. Risk register shows children's section	1/5/15					
2. An update session for all senior nursing and medical staff on the purpose and process of the risk register		on-going: new 'Risk ation distributed	managed in a timely manner  2. Minutes of	16/6/15					
3. Ensure review of risk register is standing agenda item at Directorate meetings / Clinical Governance meetings	Directorate me Now standing a	ng agenda item at eetings agenda item at ical Governance meeting	Directorate meeting / Clinical Governance meeting  3. Meeting agendas	16/6/15					
Action Plan running to time:	Yes		or meeting agentate	l					
Evidence submitted to suppo	ort update (lis	t):							
Assurance statement :									
On-going commitment continues within Directorate									
Areas of concern for escalation:									
None									



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

		, Quanty and rations sajety					
Actions	Monthly summary update on progress	Evidence required	Action completion date	Rating			
1. Anaesthetic incident	Confirmation e-mail from the lead for	1. Written	1/2/15				
reporting pilot	the anaesthetic pilot that this is	Confirmation from					
discontinued. Those	discontinued.	coordinator of					
involved in running this	Assc. Director Quality Governance and	system					
system, and other	Patient Safety attended Anaesthetic	2. Leaflet audit of					
clinical staff fully	Clinical Governance meeting in May	distribution and					
engaged with the	2015 to discuss the Trust Incident	staff survey					
review on the DATIX	reporting system in place and take	3. Newsletter					
system to improve	questions.	article					
reporting process		4. Increased					
2. Staff leaflet to	Leaflet completed, but distribution	incident reporting	1/5/15				
include reminder about	continues	through single					
rationale for single		reporting system					
reporting system		from anesthetist					
3. Reminders in	In May's edition of the Governance	and intensivists	1/5/15				
Governance Gazette	Gazette						
and via intranet and							
website about the							
SINGLE reporting							
system in the Trust.							
4. Assc. Dir. Quality,	Attended Anaesthetic Clinical		1/5/15				
Governance and	Governance meeting 14 <sup>th</sup> May and						
Patient Safety to attend	updated attendees on reporting						
Anaesthetic CG	system						
meeting for discussion							
and update on							
reporting system							

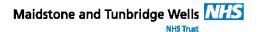
Action Plan running to time: Yes

**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:



**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	Draft CG strategy commenced. External	1. CG strategy	1/9/15	
collaborative process	consultant started Governance review in	including clear CG		
involving all stakeholders	April 2015 and is reviewing current	process from ward		
for developing and	governance arrangements and will	to board		
implementing a cohesive	produce options /recommendations for	2. M&M review		
and comprehensive	improvements	documentation of		
clinical governance system		full review process		
from ward to board		and evidence of		
2. Development of a MTW	Will continue alongside review process	clear discussions	1/7/15	
Clinical Governance	above	and shared learning	New date:	
Strategy		3. Update outline	1/10/15	
3. Mortality and morbidity	MTW mortality review process has been	and attendance	1/8/15	
review process to be	reviewed and strengthened with work			
reviewed in collaboration	continuing at Trust and directorate level.			
with stakeholders and	Quality 'Deep Dive' into current process.			
developed with	Mortality Review workshop hosted by			
exploration of further use	Dr. Foster being attended by MD and CN			
of technology and clinical	to learn other Trusts approaches			
governance processes to	(7/7/15)			
improve rigor,	Discussion underway with IT/ health			
transparency and	informatics at MTW to implement IT			
effectiveness	based system			
	NTDA to assess and provide supportive			
	feedback in August			
4. Update for staff	Will follow on from action taken above.		1/10/15	
involved at directorate				
and Trust level on their				
role in the mortality &				
morbidity review process				

Action Plan running to time: Yes

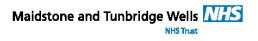
**Evidence submitted to support update (list):** External consultant update on governance review at executive meeting. Minutes of Trust Mortality Review Group meeting

#### Assurance statement :

This action plan is running to time at present

### Areas of concern for escalation:

None at present



<b>Issue:</b> The arrangement for the management and administration of topical anaesthetics was ineffective.										
<b>Lead:</b> Hamudi Kisat, C	linical Director	Operational	Lead: Jackie Tyler, I	Matron						
Actions	Monthly summary updat	te on progress	Evidence required	Action completion date	Rating					
1. Standard Operating	Completed		1. SOP for	1/5/15						
Procedure for the			children's services.							
administration of			2. Audit of							
topical anaesthetics for			prescription charts.							
children to be			3. Training records							
developed and			of staff undertaking							
implemented			PGD training							
2. Topical anaesthetics	Assessed in July 2015. Dru	ug charts		1/6/15						
for children prescribed	reviewed and topical ana	esthetics								
in all areas of the Trust	prescribed. Evidence of g	ood staff								
	awareness.									
3. A number of key	Training ongoing for Paed	diatric staff-		1/7/15						
staff to undertake PGD	all band 6 nurses rostered	d onto trust								
training to facilitate	PGD study days until end	of year to								
appropriate timeliness	enable compliance									
of prescribing.										
	Ward manager now comp	oliant and								
	able to assess staff compo	etency								
	Training continues									
Action Plan running	to time: Yes			<u> </u>						
Evidence submitted	to support update (list	t):								
Assurance statemen	t:									
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	Operation al leadership	Date to be completed	Evidence Required	Outcome/succe ss 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 Mumfor d, 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	Develop systems to	1. Identify a list of	Akbar	Akbar	1. 1/7/15	1. List of key	No patient	Relevant medical staff
	and	ensure the competence	key procedures for	Soorma,	Soorma,	2. 1/7/15	procedures	safety incidents	undergo competency
	Medical	of medical staff is	all medical staff	Clinical	Clinical		produced	caused by a lack	training for a variety of
	Services	assessed for key	2. Review SI's and	Director	Director		2. Copies of	of operator skill	medical clinical
		procedures.	complaints to				signed	or knowledge	procedures. Training
			identify any				competency	Systems in place	sessions are signed off
			particular				documents	to ensure the	for competency in
			procedures that				3. Agreement	competence of	individual skills. Non-
			have caused harm				between CD and	medical staff is	training grades have
			to patients to				Specialist	assessed for key	specific sessions which
			support				medicine	procedures.	are directed at skill and
			prioritisation of this				department lead		knowledge
			work				on		development.
							standardisation		Particular issues or
							approach		developments are
							4. Document		highlighted at clinical
							outlining agreed		governance sessions.
							standards and		
							process for the		
							assessment of		
							competency for		
							identified key		
							procedures for all		
							medical staff		

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 Safeguardi ng	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 antenatal 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 Midwifer y	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