CQC Quality Improvement Plan

Assurance Report August 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.

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. These will be tested in practice over August with full implementation in all relevant areas from the beginning of September.

Training of key staff to undertake PDG training to facilitate the appropriate timeliness of prescribing of paediatric topical anesthetic has been completed with a clear SOP in place. An audit to ascertain compliance with use of topical anesthetics is underway.

Compliance actions – Critical care

The Standard operating Procedure for ITU admission and discharges has been developed and undergone full consultation, and has been ratified at the Standards Committee. Ongoing work continues on the recruitment and consultant job planning in order to meet the required ICS core standards. Site pressures continue to affect overnight discharges with an increase in July (compared with June). Careful monitoring is in place and a longer term Trust wide plan is underway.

The outreach service is now fully recruited into posts with the development of a 24/7 Rota expected to be ready for implementation and of September 2015.

Compliance Action – Due regard for cultural, linguistic and disability background

The business case for the permanent post of Equality and Diversity lead has been agreed and recruitment will commence shortly. There has been ongoing progress with the E&D strategy and the EDS2 grading plan including collaborative working with service user groups.

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 judgment 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		Some delays in reaching agreement on final version of PEWS appropriate for all relevant areas. Approved version due to be in place w/c 10th August. Training for staff already commenced.
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		New Operational Policy ratified at August Standards committee.
CA 5 – ICU delayed discharges	Jacqui Slingsby Matron, Critical Care Directorate		
CA 6 – ICU overnight discharges	Jacqui Slingsby Matron, Critical Care Directorate		There were 0 overnight transfers at Maidstone and 8 at TWH in July. In June there were 0 at Maidstone, 4 at TWH. Plan in place to create additional capacity at TWH. **Red over 5, Amber less than 5. Green less than 3.**
CA 7 – Critical Care Outreach 24/7	Siobhan Callanan Associate		None raised

service provision	Director of Nursing		
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 / Jonathan Appleby Clinical Directors		None raised, awaiting completion of Standard Operating Procedure due 1/9/15
CA 15 – Children's Clinical governance	Karen Woods Risk and Governance Manager, Children and Women's Services		Completed compliance action
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)	Further amendments made to PEWS in conjunction with A&E over July Approved on 3.8.15 & PEWS charts at Printers PEWS chart expected from printers week commencing 10th August for trial and evaluation Full implementation across Paediatric ED, Paediatric Ambulatory and Inpatients on both sites beginning Sept	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	31/6/15 Fully implemented 1/9/15	
2. Escalation protocol reviewed alongside the PEWS chart review	Escalation protocol approved Summary of escalation protocol added to back of approved PEWs charts Draft PEWs guideline document completed			
3. Once agreed, PEWS chart and escalation protocol implemented across Children's services directorate via teaching sessions, ward level meetings, A&E and Children's services Clinical Governance meeting	PEWS Training to commenced beginning of August in all relevant areas of Trust Lead allocated Sister Rochelle Gilder Situation, Background, Assessment, Recommendation (SBAR)effective communication training to run alongside PEWs training throughout August			
PHASE 2 Electronic solution (Nervecentre) for PEWS and escalation implemented (brought forward within existing IT plan). NB excludes paediatric A&E	Awaiting completion of PEWs documentation and policy	6. Compliance audit from Nervecenter	31/12/15	
Action Plan running to time: No				
Evidence submitted to support update (list):				
Assurance statement :				
PEWs chart and training plan agreed across all departments – training already commenced. Charts due to be fully implemented by the beginning September in all areas				
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	2a. second ward round at weekends is taking place in person or by phone depending on the acuity of patients 2b. Agreement to amendments on rota to enable a 1-8compliant rota to ensure a second ward round in person at weekends to occur consistently. 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	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 Consultant Job plans under review in anticipation of the change		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 with interviews arranged for October		1/4/16	
Action Plan running to time: YES				
Evidence submitted to support update (list):				
Assurance statement :				
Fully compliant rota expected by 1/10/15				
Areas of concern for escalation:				
Potential risk of inability to recruit suitable intensivists				

Compliance action 3				CA3
Issue: *Contrary to the core standards of the Intensive Care Society: The consultant was not always available within 30 minutes. There was only one ward round per day when there should be two to comply with core standards.*				
Lead: *Greg Lawton , Clinical Director*		**Operational Lead:** *Daniel Gaughan, GM*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Travel times & distance for each consultant being reviewed to assess compliance with 30 minutes availability for each individual consultant.	This has now been assessed by the clinical director Risk assessment completed and on risk register.	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	Risk assessment completed to support mitigation until new rota commences 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 :				
Areas of concern for escalation:				
Potential risk of inability to recruit suitable intensivists				

Compliance action 4				CA4
Issue: *Contrary to the core standards of the Intensive Care Society: Admissions were delayed for more than four hours once the decision was made to admit a patient to ICU*				
Lead: *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: the ring-fencing of ITU bed will be implemented where possible. 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	SOP ratified at Standards committee August 2015		31/5/15 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)	SOP ratified at Standards committee August 2015. Further work (Task and finish group) commenced with all stakeholders working on pathways for patients in escalation areas being formulated. Version 3 in progress.		30/4/15 New date: 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: YES (to new date)				
Evidence submitted to support update (list): ICU Standard operational policy				
Assurance statement :				
No concerns				
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	SOP ratified at Standards Committee August 2015.	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.	31/5/15 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. 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: YES (new date)				
Evidence submitted to support update (list): SOP				
Assurance statement :				
Areas of concern for escalation:				

Compliance action 6			CA6
Issue: *Contrary to the core standards of the Intensive Care Society: Overnight discharges take place from the ICU.*			
Lead: *Greg Lawton, Clinical Director*	**Operational Lead:** *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 July no patients were transferred out of hours at Maidstone and 8 at Tunbridge Wells. This compares with 0 at Maidstone and 4 at Tunbridge Wells in June. 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.		1/3/15	
Action Plan running to time: **No**				
Evidence submitted to support update (list): ICU dashboard				
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 recruited into		1/9/15	
3. Implementation of a 24 hour 7 day out-reach service which will be fully integrated with critical care service	Consultation has now closed with a number of staff unable to work the 24 hr rota due to occupational health issues. The rota will be compliant and ready to operate from September 2015		1/10/15	
Action Plan running to time: YES				
Evidence submitted to support update (list): HR letter re End of Consultation				
Assurance statement :				
Team building day planned for September Recruitment completed				
Areas of concern for escalation:				
None				

Compliance action 8			CA8	
Issue: *Improvements are needed in relation to the environment in the Intensive Care Unit with regards to toilet/shower facilities for patients.*				
Lead: *Greg Lawton, Clinical Director*		**Operational Lead:** *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 approved	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	Ongoing development of 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	E&D priorities included & supported by project plan for approval by September 2015 Workforce Committee BME Forum established Plans underway to raise the profile of LGBT and Disability workforce communities in September 15. Trust has partnered with Stonewall to support LGBT staff		1/9/15	
4. Ensure current process for accessing translation services is communicated to all staff	Staff Communication circulated January 2015 – Recirculated 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/Aug 2015		1/10/15	
8. Ensure appropriate organisational governance with assurance to Trust Board in relation to Equality and Diversity	Trust Executive agreed governance proposals in July 15.		1/9/15	
Action Plan running to time: YES				
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. Audit commenced with results expected September	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	Audit underway.		1/9/15 new date 1/10/15	
Action Plan running to time: Yes (new date)				
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		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: YES				
Evidence submitted to support update (list):				
Assurance statement :				
L&D have allocated all our Security Team login details for the on-line induction.				
Areas of concern for escalation:				
We were finding that our Officers were missing MTW mandatory Training sessions due to operation tasking's, L&D have now arranged for on-line training for the Security Team – Review progress 25th Aug 2015				

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 excepted to be completed 1/9/15	
2. Governance page to be developed on the intranet and MTW website with clear signposting to Incident Reporting section	Allocated lead for this work. Intranet completed. Bolder reporting incident button already changed on intranet front page Work on website commenced		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 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.				
Areas of concern for escalation:				

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 & Jonathan Appleby, Clinical Director*		**Operational Lead:** *Hamudi Kisat, Clinical Director & Jonathan 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	Clinical Director attended surgical CG meeting to present papers	1. Minutes of joint meeting 2. Standard Operating Procedure 3. Audit of practice 4. MTW Clinical Governance Strategy 5. Agenda, Minutes and attendance records from CG meetings	1/5/15	
2. Standard Operating Procedure for care of children on surgical pathway on paediatric wards	Draft SOP completed and circulated for comment- to be finalised and ratified by end of August		1/6/15 New date: 1/9/15	
3. Implementation of the SOP into routine daily practice	Patients admitted to Inpatient Ward now shared care between Paediatrics and Speciality Teams Audit planned September 2015		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 Governance report expected August 2015		1/9/15	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list): draft SOP				
Assurance statement :				
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 plus induction groups	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): Risk update, Induction agenda's, CG agenda's				
Assurance statement :				
Work on-going within the directorate to increase staff awareness and involvement with paediatric risks				
Areas of concern for escalation:				
Nil				

Compliance action 16				CA16
Issue: *There were two incident reporting systems, the trust electronic recording system and another developed by consultant anesthetists and intensivists one for their own use. The trust could not have an overview of all incidents and potentially there was no robust mechanism for the escalation of serious incidents. Therefore opportunities were lost to enable appropriate action to be taken and learn lessons.*				
Lead: *Avey Bhatia, Chief Nurse*		**Operational Lead:** *Jenny Davidson, Assc Director Governance, Quality and Patient Safety*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Anaesthetic incident reporting pilot discontinued. Those involved in running this system, and other clinical staff fully engaged with the review on the DATIX system to improve reporting process	Confirmation e-mail from the lead for the anaesthetic pilot that this is discontinued. 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, distribution due for completion 1/9/15		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	Full review undertaken between April and July 2015 External Governance report with recommendations expected August 2015	1. CG strategy including clear CG process from ward to board 2. M&M review documentation of full review process and evidence of clear discussions and shared learning 3. Update outline and attendance	1/9/15	
2. Development of a MTW Clinical Governance Strategy	Will commence once report and recommendations considered and plan made		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. Agreement with IT/ health informatics at MTW to implement IT based system as a pilot in Autumn Visit to trust with established process planned 11th August. 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):				
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	Information regarding PGDs including Standard operating policy available on intranet Lead for ward identified – Sister Rochelle Gilder PGD now available in all areas in purple PGD folders		1/5/15	
2. Topical anaesthetics for children prescribed in all areas of the Trust	Topical anaesthetic cream now prescribed at all pre-assessment clinics Audit to be undertaken in August 15		1/6/15 Audit results due 1/9/15	
3. A number of key staff to undertake PGD training to facilitate appropriate timeliness of prescribing.	All key staff fully trained and signed off (100%) Training for other staff well in progress (75% trained) Assessors now trained within Paediatrics which will improve assessment processes		1/7/15	
Action Plan running to time: Yes				
Evidence submitted to support update (list):				
Assurance statement :				
Running to schedule				
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	Exec Lead	Operational leadership	Date to be completed	Evidence Required	Outcome/success criteria	Update Summary
M4	Corporate	Ensure that up-to-date clinical guidelines are readily available to all staff.	1. Review of present system of clinical guideline / documentation access and management 3. Identification of areas for improvement and consult on possible solutions 4. Options to be presented at TME	Avey Bhatia, Chief Nurse / Paul Sigston, Medical Director	Donna Jarret, Director of Informatics Jenny Davidson Assc Dir, Gov, Quality, Patient Safety	1. 1/8/15 3. 1/8/15 4. 1/8/15	1. Review of current system and options appraisal paper 2. Survey of staff views 3. Minutes from TME meeting 4. Task Finish group report	Clinical guidelines up to date and accessible to staff	Review of clinical guidelines document access and management has been undertaken and a survey of staff views/experiences completed. Areas of improvement identified and a solution is being presented at TME September 2015
M&T24	Corporate	Consider collating performance information on individual consultants. Where exceptions are identified, these should be investigated and recorded.	4. Review of directorate reports,overall data, mortality exceptions at monthly Trust Mortality Review Group meeting. MRG to authorise investigations by independent clinician as required (see CA17)	Glenn Douglas, Chief Executive	Paul Sigston, Medical Director	4. 1/8/15	1. Agenda minutes of directorate CG and MRG meetings 2. Report provided to MRG by Clinical Directors 3. Exception investigations by independent clinicians 4. Mortality review Guidelines	MTW collates performance information on individual consultants. Where exceptions are identified, these are investigated and recorded.	This work is ongoing but underway. Mortality will be subject to a Quality Committee deep dive review in October 2015 Visits to other Trust to review their processes booked

TW38	Corporate	Review the ways in which staff can refer to current clinical guidance to ensure that it is easily accessible and from a reputable source.	see M4 above. In addition: 1. Develop Trust guidelines on the development and management of clinical guidelines, protocols, policies and documents to ensure agreement on expected standards	Avey Bhatia, Chief Nurse	Paul Sigston, Medical Director	1. 1/8/15	1. Trust Guidelines on the development and management of clinical guidelines, protocols, policies and documents 2. Audit to standards	Staff are able to access high quality clinical guidance	Review of clinical guidelines documenet acess and management has been undertaken and a survey of staff views/experinces compelted. Areas of improvement identified and a solution is being presented at TME September 2015
M13	Diagnostics Therapies and Pharmacy	Develop systems to ensure that medicines are stored at temperatures that are in line with manufacturers' recommendations.	6. Consideration of business case at TME	Paul Sigston, Medical Director	Jim Reside, Chief Pharmacist John Kennedy, Deputy Chief Nurse	6. 1/8/15	1. Purchase order confirmation from procurement 2. Replacement programme confirmation from Directorate lead 3. Data from daily fridge monitoring and escalation to EME / pharmacy 4. Business Case 5. Minutes of TME where buisness case considered	Systems in place to ensure that medicines are stored at temperatures that are in line with manufacturers' recommendations.	A business case to look at options for ward/room temperature monitoring is currently being completed by Michael Chalklin with assistance for Helen Burn.

TW39	Surgery	Review current nil-by-mouth guidance to ensure that it is consistent with national standards; patient information leaflets should be standardised and reflect national guidance.	2. Provide update / education of all relevant staff	Avey Bhatia, Chief Nurse	Siobhan Callanan, ADN Planned care	2. 1/8/15	1. New Fasting policy 2. update / education program with attendance list 3. Audit showing compliance with policy	Patients are provided with consistent advice and care around fasting that is reflective of national guidance	1.NBM policy in process of consultation 2.Training programme to be agreed once policy ratified 3. Audit to commence 3 months following training programme