North Middlesex University Hospital NHS
NHS Trust

BACKGROUND INFORMATION FOR THE BEH NCL JHOSC SUB GROUP MEETING (13 MAY 2016)

Risk and Quality Committee

MEETING DATE:	28th April 2015

TITLE:	CQC action plan assurance update

AGENDA ITEM:	4.1	**PAPER:**	E

EXECUTIVE SUMMARY: This paper outlines the Trust's response to the recommendations contained in the CQC Quality Report and the action it is taking to improve the quality of services provided. The Trust's position against the implementation of the action plan as at **16th April** is included as an appendix.

ACTION REQUESTED OF THE MEETING:

For discussion	x	For noting	
For decision			
For assurance	x		

Which Strategic Objective does this paper impact most upon?:	SO1 – Provision of Excellent Clinical Outcomes SO2 – Positive experiences for patients, GPs and all stakeholders
How does the paper demonstrate progress towards the specified strategic objective?:	This paper includes the Quality Improvement plan being implemented to address the recommendations arising from the CQC Inspection of June 2014. Its Implementation will ensure the Trust's services are rated as at least 'good' when they are next inspected by the CQC.

LINKS WITH THE:		
BAF:	Corporate Risk Register 2583: CQC Rating of Requires Improvement on FT authorisation	**Risk score:** 15
IPR:	N/A	
Other:	N/A	

THIS PAPER HAS BEEN PREVIOUSLY CONSIDERED BY:	None

AUTHOR AND TITLE:	Dane Satterthwaite, Associate Director of Governance

RISK & QUALITY COMMITTEE MEETING
Tuesday, 28th April 2015

CQC Quality Improvement Plan monitoring process

1.0 Introduction

Following receipt of the CQC Quality Report from the inspection during June, the Trust has considered and responded to each recommendation contained in the Quality Report. Where the Trust has accepted the recommendation, the Trust has agreed to undertake remedial action. The Trust is committed to implementing a Quality Improvement Plan that has been designed in response to each of the accepted recommendations contained in the Quality Report. This Quality Improvement Plan has been designed with the objective of resulting in improvements to the quality of services provided by the Trust so as to ensure they get ratings of at least 'good' when they are next inspected by the CQC.

This paper outlines the governance process for monitoring and assuring the implementation of the Quality Improvement Plan.

2.0 Quality Improvement Plan

Where the Trust has accepted a recommendation contained in the CQC Quality Report, the Trust has identified what level of the organisation is required to take action in response to the recommendation. Some recommendations require action to be taken both at a corporate level and local CBU level, or in different CBUs. Therefore each recommendation is assigned to each of the CBUs that are required to undertake action. Where a recommendation requires action to be taken by more than one CBU, copies of the recommendation appears aligned to each CBU in the Quality Improvement Plan. This will ensure effective monitoring of the implementation of actions across each CBU.

Each recommendation is assigned to the relevant CBU Managing Director, Clinical Director or Head of Nursing, or corporate manager to devise an action to improve quality and identify the evidence that will demonstrate this action has been implemented effectively.

Each recommendation is RAG rated based on the following:

1. Red:
    a. Action identified but implementation has not yet started
    b. Action underway but progress is behind plan – recovery plan required.
2. Amber
    a. Action underway and is on schedule
    b. Action is complete, but evidence not yet reviewed by Associate Director of Governance
3. Green
    a. Evidence demonstrating action has been effectively implemented received and reviewed by the Associate Director of Governance.

3.0 Key achievements to date

Since the previous Risk and Quality Committee, the following CQC actions have been delivered:

Must do recommendations:

1. Mandatory training compliance across the Trust reached the 80% target as at 08/04/2015.

2. Ambulatory Care Unit and the Day Hospital have relocated to their permanent and refurbished accommodation in Pymmes
3. Vacating Ambulatory Care and Day Hospital from Clinic 4 and implementation of key OPD improvements including the prohibition of short notice clinics. With the exception of urgent cancer clinics, all clinics must be arranged at least 2 weeks in advance.

Should do recommendations:

1. Approved the recruitment of an additional pain nurse to increase service provision to 7/7
2. Approved the recruitment of an additional End of Life CNS to increase service provision to 7/7
3. Increased safety and quality in A&E by providing improved accommodation for psychiatric patients, improved medicine security and improved access to food and drink for patients.
4. Improved standard of documentation across CBU2 and Maternity
5. Improved process for booking clinic appointments, online/email address introduced, staffing for appointments call centre expanded resulting in 90% of calls being answered within 30 seconds. Short notice clinics prohibited except for target patients.
6. Installed 8 new permanent spaces in the Mortuary
7. Introduced new Peri-natal notes for Maternity to improve accessibility and quality of medical records.
8. The Trust is conducting a review of the implementation of the Barnet, Enfield and Haringey Clinical Strategy with Sweet Group, this report will go to May's Trust Board.
9. Increased dementia awareness training with an additional 186 staff trained since 1st January.
10. Palliative Care and maternity guidelines have been reviewed.
11. Audited the use of new DNA CPR Forms to improve documentation of competency and DNA CPR discussions. This audit demonstrated that of the 79 DNACPR forms reviewed 50(63%) had been discussed with a relative or family/carer 19(24%) had been discussed with the patient in question 9(11%) had been discussed with both the patient and family/carer and 17(22%) had been signed in the patients best interests without communication with either the patient or family/carer.
12. Increased the number of substantive nursing staff in Neonatal Unit.

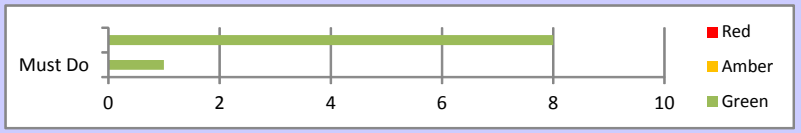
3.0 Conclusion

The committee is asked to discuss this paper.

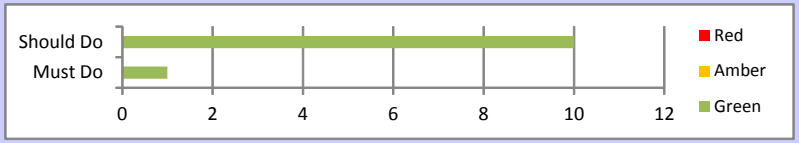
Dane Satterthwaite
Associate Director of Governance
16th April 2015

Appendix 1 – CQC Quality Improvement Plan score card 16th April 2015

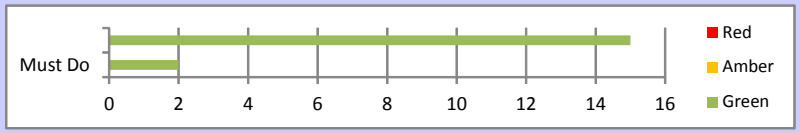
Corporate	Number of	Current Status of Recommendation			
Type of Recommendation:	Recommendations	Red	Amber	Green	Total
Must Do	1	0	0	1	1
Should Do	8	0	0	8	8



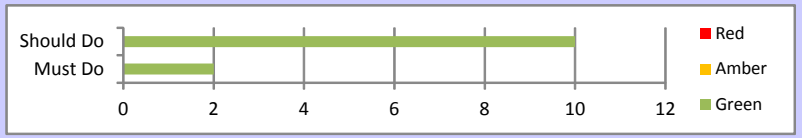
CBU1	Number of	Current Status of Recommendation			
Type of Recommendation:	Recommendations	Red	Amber	Green	Total
Must Do	1	0	0	1	1
Should Do	10	0	0	10	10



CBU2	Number of	Current Status of Recommendation			
Type of Recommendation:	Recommendations	Red	Amber	Green	Total
Must Do	2	0	0	2	2
Should Do	15	0	0	15	15

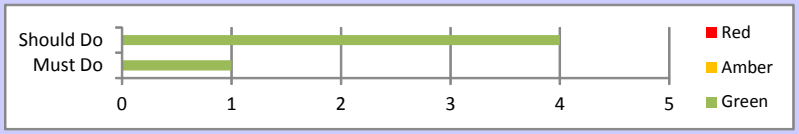


CBU3	Number of	Current Status of Recommendation			
Type of Recommendation:	Recommendations	Red	Amber	Green	Total
Must Do	2	0	0	2	2
Should Do	10	0	0	10	10

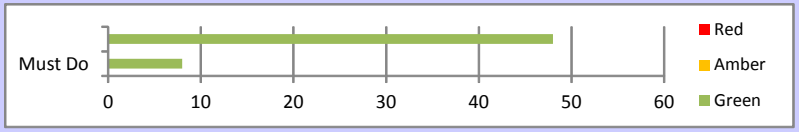


CBU4	Number of	Current Status of Recommendation			
Type of Recommendation:	Recommendations	Red	Amber	Green	Total
Must Do	1	0	0	1	1
Should Do	1	0	0	1	1

CBU5	Number of	Current Status of Recommendation			
Type of Recommendation:	Recommendations	Red	Amber	Green	Total
Must Do	1	0	0	1	1
Should Do	4	0	0	4	4



TRUSTWIDE TOTAL	Number of	Current Status of Recommendation			
Type of Recommendation:	Recommendations	Red	Amber	Green	Total
Must Do	8	0	0	8	8
Should Do	48	0	0	48	48



Appendix 2 – CQC Quality Improvement Plan

Must Do/ Should Do	CBU/Corporate	Core Service	Domain	CQC Recommendation	Further Action to be taken	Evidence of implementation	Action Lead	Due date for completion	Date Completed	RAG status	Update
Must	C	Trustwide	Well-led	Take action to improve its training - both mandatory and non-mandatory - and its recording and administration of training records and training renewal requirements	1. Agree recovery plan and trajectories to deliver 80% compliance with statutory and mandatory compliance by December 2014. 2. Deliver 80% with statutory and mandatory training compliance by December 2014 3. Implement action plan in response to Compliance Action in inspection report.	1. Statutory and Mandatory Training Recovery plan 2. Monthly CBU performance against Statutory and Mandatory Training KPIs	1. Stanley Okolo 2. All CBU Management Teams	1. 30/08/2014 2. 31/12/2014	1. 29/08/2014 2. Ongoing	G	08/04/2015 - Trustwide Mandatory Training Compliance = 80.1% versus trajectory of 80% Ongoing performance to be tracked through Performance Management Framework and monthly CBU performance meetings.
Should	C	Trustwide	Responsive	Improve patient discharge arrangements at weekends	1. Implement Nurse led discharges to support expedited discharges 2. Review therapies and AHP working patterns to support increased discharges at weekends. 3. Explore increasing number of doctors at weekends and extension of Ambulatory Care opening at weekends 4. Introduce improved medical handover process to track potential patient discharges over the weekend. 5. Increase clinical capacity on the wards over weekends to increase discharges.	1. Nurse Led Discharge process in place. 2. Increased discharges before 10am. 3. Matron on over weekends to expedite weekend discharges 4. Nurse led discharge continues to be rolled out in surgery 5. Break the cycle project work with key external stakeholders 6. Daily AMIC list to increase the visibility of AMIC patients to improve discharges.	1. Paul Reeves 2. Joanne McCaffrey & Achim Schwenk 3. Richard Gourlay & CBU2	31/12/2014	16/04/2015	G	External review of therapies in July 2014 indicated capacity within the team to support weekend discharges. Phase 2 of this review to be arranged for November 2014 in order to agree an action plan for 7 day working within Therapies. Ongoing improvement work will be monitored via Break The Cycle and Inpatient Transformation Board
Should	C	Trustwide	Well-led	Review arrangements for the consistent capture of learning from incidents and audits and ensure that learning and audit data is always conveyed to staff	1. Appoint new Head of Clinical Governance and Risk Management 2. Internal Audit Review incident learning process and implement improved system for learning from incidents and sharing lessons learned with front line staff	1. new Head of Clinical Governance and Risk Managmenet post created 2. Internal Audit Lessons Learned Audit Report and implementation of recommendations	Dane Satterthwaite	1. 31/12/2014 2. Report completed August 2014, action plan due date for implementation 31/12/2014	1. 03/11/2014	G	1. Head of Clinical Governance and Risk Management commenced in post. 2. SI process review undertaken. Internal Audit Action plan recommendations are being implemented. 3. Clinical Audit process reviewed.
Should	C	Trustwide	Effective	Review the provision of specialist pain nurse support across the whole hospital	Review provision of specialist pain nurse service to deliver 7 day service across Trust.	Paper to report findings of review of pain nurse specialist service. Expanded Pain nurse service to 7 day service	Paul Reeves	31/03/2015	16/04/2015	G	16/04/2015 Additional Pain Nurse being recruited to expand team to three giving 7/7 service provision. Also, Anaesthetics demand and capacity review undertaken, need for additional Anaesthetist with interest in pain identified. Additional anaesthetist 50:50 pain service being recruited.
Should	C	Trustwide	Well-led	Ensure consistent ownership and knowledge of the risk register across all nursing and medical staff	1. Appoint new Head of Clinical Governance and Risk Management. 2. Provide Ward managers and CNS with risk management training and raise awareness of CBU risk registers for managers across the Trust.	Training records, enhanced CBU risk registers.	Dane Satterthwaite	31/12/2014	1. 03/11/2014	G	1. Head of Clinical Governance and Risk Management commenced in post 2. Risk Register presentation delivered to Matrons and Ward sisters meeting (05/11/2014)
Should	C	Trustwide	Well-led	Review development and promotional prospects and progress for staff such as healthcare assistants	Review KSF for HCSW Review HCSW establishment and ensure promotion opportunities for HCSW are promoted internally Approach LETB to implement additional Assistant Practitioner posts at the Trust	Paper to report findings of review of HCSW KSFs, HCSW establishment and promotion opportunities. LETB bid submission for AP posts	Paul Reeves & Helen Rushworth	31/12/2014	16/04/2015	G	HCSW Skill mix review undertaken. Monthly HCSW forum launched. HCSW competency booklet developed and currently being implemented across Trust. Trust has obtained funding for 5 AP posts for 2015/16 from the LETB.

Should	C	Trustwide	Responsive	Accelerate plans to move to 7-day working across all core services. For example, some investigations are not available 7 days a week and none are 24/7. The support for patients recovering from surgery is limited at weekends with no access to occupational therapists, physiotherapists or clinical nurse specialists.	1. CBU3 Management Team to review provision of Therapies services OOH and at weekends and develop business case to extend service to weekends.	Business Case for extending Thearpies services to weekends and provision of services.	Jo McCaffrey & Achim Schwenk	31/03/2015		G	External review of therapies in July 2014 indicated capacity within the team to support weekend discharges. Phase 2 of this review began 10/11/14 in order to agree an action plan for 7 day working within Therapies for January 2015. Therapies 7 day working project plan developed. EoLC 7/7 service will be launched following recruitment of additional CNS following successful bid to MacMillan. 3rd Pain Nurse CNS being recruited to enable 7/7 Pain service which will be supported by additional anaesthetic consultant with special interest in pain.
Should	C	Trustwide	Safe	Review the impact of the Barnet, Enfield, Haringey strategy, its impact on staffing levels and its potential impact on quality of care.	1. Undertake interim review of impact of BEH Clinical Strategy and potential impact on quality of care. 2. Commission comprehensive review of implementation of BEH Clinical Strategy. 3. Further skill mix review undertaken. Assured continued 1:6 qualified nurse to patient skill mix provision. AUKUH acuity tool used to ensure skill mix is appropriate.	Interim Board Paper reporting on evaluation of BEH clnical strategy on quality of care. Sweet Group report on BEH Impact	1. Richard Gourlay 2. Richard Gourlay 3.Paul Reeves	1. 30/09/2014 2. 31/03/2014 3.30/10/2014	1. 25/09/2014	G	1. Interim review of impact of BEH Clinical Strategy submitted to Trust Board in September. 16/04/2015 - Data submitted to Sweet Group for report to be received by end of April. Report to be reported to part 1 of May's Trust Board.
Should	C	Medicine	Well-led	Review the needs of people living with dementia across the hospital to ensure that they are being met	1. Appoint new Nurse Lead for dementia to support Clinical Lead fo dementia 2. Roll out additional Dementia and delirium training 3. Presentation to CEOs & Chairs at the Transformation Board 18.09.14. 4. Write revised strategy 5. Participate in Haringey CCG MCA/DOLs Champions to improve support for Dementia care patients. 6. Expansion of Dementia training in ED and across the organisation. 7. Dementia steering group launched led by Deputy Director of Nursing and Consultant Lead for Dementia Care.	Reinvigorated Dementia Steering Group Improved Dementia Awareness Training Rate	1. Paul Reeves 2. Dr Sohpie Edwards and new Lead Nurse for dementia 3. Dr Edwards and new Nurse Lead	1. 31/10/2014 2. 31/12/2014 3. 30/11/2014 4. 30/11/2014 5. 31/01/2015	1. 31/10/2014	G	1. New Dementia Nurse lead appointed (MB CBU2 Matron) to support Clinical Lead for Dementia 2. Dementia Champions appointed for each ward. 4. Dementia Strategy Working Group to meet first week in December. 5. Julie F to lead on Trust's engagement with Haringey CCG's MCA/DOLS Champsions initiative. 6. trust has appointed Dementia Lead Matron from another Trust to be Matron for Acute Medicine wards in the Tower.
Must	1	Trustwide	Well-led	Take action to improve its training - both mandatory and non-mandatory - and its recording and administration of training records and training renewal requirements	1. Agree recovery plan and trajectories to deliver 80% compliance with statutory and mandatory compliance by December 2014. 2. Deliver 80% with statutory and mandatory training compliance by December 2014 3. Implement action plan in response to Compliance Action in inspection report.	1. Statutory and Mandatory Training Recovery plan 2. Monthly CBU performance against Statutory and Mandatory Training KPIs	1. Stanley Okolo 2. All CBU Management Teams	1. 30/08/2014 2. 31/12/2015	1. 29/08/2014 2. Ongoing	G	Trustwide performance 80.1% CBU1 = 76.4% 08/04/2015 Performance to be monitored via Performance Management Framework.
Should	1	Accident & Emergency	Safe	Review the use of the decontamination room in A&E which poses a contamination risk to the rest of the hospital. This was closed during our inspection following highlighting our concerns.	1. Amend Major Incident Plan to reflect decontamination room being taken out of use. 2. Conduct review of decontamination room at Emergency Planning Committee	Amended Major Incident Policy (version 10.6 available on intranet) Emergency Planning Committee	Sarah Eastwood.	1. 30/08/2014 2. 31/12/2014	1. 29/08/2014	G	Major Incident Plan amended and available on intranet. Awaiting outcome of Emergency Planning Committee review of Decontamination Room. Decontamination Room labelling removed and room now clearly identified as Shower Room 30.
Should	1	Accident & Emergency	Safe	Ensure that medicines are stored safely in A&E and that systems for recording take home medication are consistent throughout the hospital	1. Implement pre-pack register. 2. Change drug storage arrangements	For discussion and action planning at CBU1 Management Meeting 05.09.14	Sarla Drayan / Natasha Knutt	01.10.14	16/04/2015	G	19/01/2015 Swipe card access to storage rooms installed. Quote received, PO raised on APTOS for lockers. Awaiting delivery of new medication storage lockers. 16/04/2015 - Medicine lockers installed.

Should	1	Accident & Emergency	Safe	Ensure that staff undertake risk assessments for those patients at risk of falls or pressure sores	1. Agree recording process. 2. Staff training for all ED staff.	Audit sample of clinical records	Anna Langthorne / Natasha Knutt	01.10.14	04/20/2015	G	Falls risk assessments tool implemented in A&E. ADG awaiting receipt of audit results 01/12/2014 - Added to A&E Departmental action plan. Audit delayed. 04/02/2015 Audit received for Dec 14 and Jan 15 Pressure Area documentation = 56%, NEWS chart usage = 86%, Falls protocol = 44%
Should	1	Accident & Emergency	Safe	Review the risk assessments for the ligature points noted in the psychiatric assessment room in A&E	Health and Safety Manager to review ligature risks and remove any risks identified.	Report from the Estates Department confirming risk level.	Anna Langthorne / Natasha Knutt	22.09.14	17/03/2015	G	Waiting for Estates to cost and supply resources required 13.10.14. Quotes for works being obtained. 01/12/2014 Kelly Eaton chasing Bouygues on behalf of CBU. 12/12/2014. Quotes to be provided by Bouygues by 21/01/2015 10/02/2015 Ceiling vent resolved, alarm strip being removed 10/02/2015, furniture is on order and padding for the corner of the wall is due for delivery 02/03/2015, door handles being resolved, were scheduled to be removed 06/02/2015 but this was not done, Estates are chasing. 17/03/2015 all ligature points removed. Temporary padded protection for corner of wall installed.
Should	1	Accident & Emergency	Responsive	Ensure that there is adequate provision of food and drink for patients in A&E who are waiting for long periods including at night.	Cost and secure agreement to recruit staffing for this role. Implement enhanced food & drink service provision.	Staff in post and new service implemented	Anna Langthorne / Natasha Knutt	01.11.14		G	01.11.14 - Depends on recruitment to HCSW posts - update needed from A&E Matron 19/01/2015 Estates are reviewing provision of vending machines in ED to improve access to food and drink. 08/04/2015 - House keeper shifts have been increased and split to increase coverage to assist patients with food and drink.
Should	1	Accident & Emergency	Responsive	Improve investigation and response times to complaints particularly in A&E and outpatients	1. Improve performance management of complaints response times in A&E and Outpatients. 2. Deputy Director of Nurses appointed as Executive Lead for Patient Experience to lead improvements in complaints management 3. Review provision of Clinical Governance and Risk Coordinators across trust to provide additional support for complaints response.	Improved complaints response performance	1. CBU Management Teams (CBU1) 2. Julie Firth 3. CBU Management Team (CBU1)	31/03/2015	15/04/2015	G	15/04/2015 - Improvements in turn around times for complaints being delivered. Presently 7 overdue complaints. Ongoing performance to be monitored via complaints tracker and performance management framework.
Should	1	Accident & Emergency	Well-led	Ensure that the lines of responsibility between A&E and childrens' services over the responsibility for the paediatric A&E are clear to staff during a period of change.	Confirmation of the agreed change in professional reporting arrangements for Paediatric A&E nursing staff to be communicated to all A&E staff.	Formal letter communicating the professional reporting change to be drafted and sent to all staff working in A&E as well as the Managing Director for CBU 5 for onwards communication to her teams	1. Roberta Fuller	31/12/2014	w/c 08.09.14	G	Formal letter communicating the professional reporting change to be drafted and sent to all staff working in Paediatric A&E as well as the Managing Director for CBU 5 for onwards communication to her teams 01/12/2014 - Overdue action Anna L and Roberta to agree wording and send to every substantive member of Paediatric A&E staff. Collect minutes for joint meetings which have been launched. 05/02/2015 letter sent to staff and copy received by DS.

Should	1	Accident & Emergency	Safe	Improve consistency of use of early warning scores for deteriorating patients	Management discussion at the CBU1 Management meeting w/c 01.09.14 and agreed communication plan.	Audit sample of clinical records	Anna Langthorne / Natasha Knutt	w/c 08.09.14	04/02/2015	G	NEWS Charts rolled out in A&E. Audit of sample of clinical records by 14.11.14. Awaiting receipt of audits 01/12/14 Audits not started in November, added to A&E Departmental action plan with revised due date of 31/12/14. 19/01/2015 - Awaiting receipt of audit reports. 04/02/2015 - Audit for December and January received NEWS chart usage = 86%
Should	1	Accident & Emergency	Responsive	Improve the privacy and dignity of patients during the reception process and waiting times to see a clinician within the Urgent Care Centre during the reception process.	1. Conduct audits of complaints relating to privacy and dignity whilst waiting for treatment / consultation in A&E in the past 12 months. 2. Review use of security desk and explore possible refurbishment as private cubicle for patients attending UCC	Patient experience survey - to be designed and delivered by the A&E team. Plus reduction in complaints regarding privacy & dignity whilst waiting in A&E	Anna Langthorne / Natasha Knutt	01.11.14 to give time to gather data on patient experience. 2. 31/01/2015		G	01.12.14 Urgent Care Centre Navigator Booth being created as part of the development of UCC model of care. £50k set aside to complete the work. Project delayed pending CCG agreement to commission UCC model of care. Further meeting 05.12.14. 19/01/2015 - awaiting update on progress regarding UCC commissioning decision. Refurbishment works business case being scoped with Bouygues pending commissioner decision. 08/04/2015 - Signs put up advising patients who want private appointment to inform reception.
Should	1	End of Life Care	Safe	Review inconsistency around documentation of 'do not attempt cardio-pulmonary resuscitation' DNA CPR forms	Launch British Resus Council DNA CPR forms which capture capacity assessment	Revised DNA CPR form in use and audit of compliance with mental capacity assessments in place	Vikki Howarth	30/11/2014	14/10/2014	G	New DNAR forms launched at Grand Round 7th October 2014. All previous DNAR forms removed on 13th and 14th October and replaced with new version. Audit of new forms planned for end of November. Audit report received. Audit to be repeated in March 2015. 17/03/2015 March DNACPR audit received.
Must	2	Trustwide	Well-led	Take action to improve its training - both mandatory and non-mandatory - and its recording and administration of training records and training renewal requirements	1. Agree recovery plan and trajectories to deliver 80% compliance with statutory and mandatory compliance by December 2014. 2. Deliver 80% with statutory and mandatory training compliance by December 2014 3. Implement actio nplan in response to Compliance Action in inspection report.	1. Statutory and Mandatory Training Recovery plan 2. Monthly CBU performance against Statutory and Mandatory Training KPIs	1. Stanley Okolo 2. All CBU Management Teams	1. 30/08/2014 2. 31/12/2016	1. 29/08/2014 2. Ongoing	G	Trustwide performance = 80.1% CBU2 = 78.9% 08/04/2015 Ongoing performance to be monitored via Performance Management Framework
Must	2	Medicine	Responsive	Ensure that the provision of ambulatory care maintains people's privacy and dignity	1. Complete project in place to temporarily relocate OPAU and Day Hospital to improve patient experience pending completion of permanent relocation of Ambulatory Care Service in February 2015 2. Complete project to permanently relocate OPAU, Day Hospital and Ambulatory Care Unit in better accommodation	1. Temporary relocation of OPAU and Day Hospital to temporary accommodation (Project led by Natasha Black) 2. Permanent relocation of OPAU, Day Hospital and Ambulatory Care to permanent refurbished accommodation	1. CBU2 Management Team 2. CBU2 Management Team	1. 22/09/2014 2. 28/02/2015	1. 05/10/2014 17/03/2015	G	OPAU & Day Hospital moved to Tower Zero on 5th October 2014. New Ambulatory Emergency care Unit due to move to Pymmes Zero February 2015. 17/03/2015 New Ambulatory Care Unit and day hospital opened.
Should	2	Medicine	Safe	Improve medical recording to remove anomalies and inconsistencies in records, paying particular attention to elderly care wards and take steps to improve the security of records in Surgery	1. Appoint 2 Practice Development Nurses (PDNs). 2. Conduct programme of documentation audits across wards. 3. Re-launch regular documentation audit reporting to Patient Safety Group.	1. Audit documentation standards and completion of documentation requirements across Medicine and Care of the Elderly.	Anna Langthorne	30/11/2014	10/02/2015	G	SMT 10/11/14 - Local audits yet to be undertaken across Acute Medicine and Care of the Elderly. Nursing documentation audits to be undertaken in November 10/02/2015 Documentation audits received from Head of Nursing.

Must	3	Outpatients	Responsive	Take action to ensure that outpatients department is responsive to the needs of patients in that appointments are made in a timely manner, those with urgent care needs are seen within target times, cancellations are minimised and complaints are responded to.	1. Identify and agree trust wide target time for patients to receive routine new out patient appointment e.g. within 10 working days. 2. Develop action plan to deliver agreed target. 3. Review out-patient waiting times performance for routine and urgent patients. 4. Develop KPIs to demonstrate performance. 5. Encourage use of Chose and Book by local GPs. 6. Review escalation process is robust to address access issues. 7. Monitor complaint turn around times and review complaint issues to ensure addressed 8. Review level of cancellations, agree authorisation and criteria for cancellations 9. identify agreed target level	1. Deliver reduced level of cancellations 2. Delivery timely responses to complaints	Sara Davenport	31/12/2014	16/04/2015	G	16/04/2015 - with exception of Urology and Colorectal (which have both seen significant increases in 2 week referrals), Trust is consistantly hitting 2 week cancer wait targets at specialty level as well as composite trust level. Continue to consistently hit RTT but patients are getting appointemtns within 8 weeks except for endocrinology. Trust has initiated email address for patients to cancel and amend clinic appointments. Additional staff available to call centre = 90% of calls currently answered within 30 seconds. Short nitce clinics prohibited (except for 2 week cancer target patients). All clinics now require 2 weeks notice for patients. Waiting list initiatives enable provision of weekend clinics. Presently there is only 1 outstanding complaint for OPD.
Must	3	Trustwide	Well-led	Take action to improve its training - both mandatory and non-mandatory - and its recording and administration of training records and training renewal requirements	1. Agree recovery plan and trajectories to deliver 80% compliance with statutory and mandatory compliance by December 2014. 2. Deliver 80% with statutory and mandatory training compliance by December 2014 3. Implement actio nplan in response to Compliance Action in inspection report.	1. Statutory and Mandatory Training Recovery plan 2. Monthly CBU performance against Statutory and Mandatory Training KPIs	1. Stanley Okolo 2. All CBU Management Teams	1. 30/08/2014 2. 31/12/2017	1. 29/08/2014 2. Ongoing	G	Trustwide performance = 80.1% CBU3 = 81.4% 08/04/2015 Ongoing performance to be monitored via performance management framework
Should	3	Outpatients	Responsive	Improve investigation and response times to complaints particularly in A&E and outpatients	1. Improve performance management of complaints response times in A&E and Outpatients. 2. Deputy Director of Nurses appointed as Executive Lead for Patient Experience to lead improvements in complaints management	Improved complaints response performance	1. CBU Management Teams (CBU3) 2. Julie Firth	31/03/2015	15/04/2015	G	CBU have implemented a weekly complaints action tracker. 15/04/2015 only 1 overdue Outpatients complaint. Ongoing performance to be managed via Complaints Tracker and performance management framework.
Should	3	End of Life Care	Effective	Review and implement a system for updating national guidelines in maternity and palliative care	Current End of Life Care guidelines are in line with national recommendations. Guidelines will be reviewed and updated if new guidance is published. Guidelines routeinly reviewed every 2 years.	Revised guidelines available on intranet.	Dr Hagena (Consultant Palliative Care)	Completed.	27/10/2014	G	Completed.
Should	3	End of Life Care	Safe	Improve documentation around assessment of mental capacity in end of life care.	Launch revised DNA CPR forms to capture assessment of capacity.	Audit of DNA CPR form completion to include Mental Capacity Assessment	Vikki Howarth	30/11/2014	14/10/2014	G	New DNAR forms launched at Grand Round 7th October 2014. All previous DNAR forms removed on 13th and 14th October and replaced with new version. Audit of new forms planned for end of November. Initial audit report received. 19/01/2015 Audit to be repeated in March 2015. 17/03/2015 - March DNACPR audit recieved.
Should	3	End of Life Care	Responsive	Improve documented guidance for staff around referral of patients to palliative care	Reviewed referral criteria for patients requiring palliative care to be agreed and disseminated via the intranet.	Renewed referral criteria published.	Dr Hagena (Consultant Palliative Care)	30/09/2014	27/10/2014	G	Completed and available on Trust intranet. Hard copies of referral guidelines available on every ward. Medical Grand Round Training Presentations provided.

Should	3	End of Life Care	Responsive	Increase mortuary capacity beyond current temporary arrangements	Install additional refrigerator in mortuary to increase permanent capacity. Alarms on temporary fridges connected to switchboard.	Increased Mortuary Capacity	Geoff Benge	10/04/2015		G	Non-binding quote obtained from Bouygues for 2 additional 5 body bays. This will increase our capacity by 10 spaces. HTA action plan to be submitted by 30/12/14. 10/02/2015 - Orders for additional fridges placed 8 weeks lead in time for delivery plus 2 additional weeks for installation, attempting to negotiate expedited delivery (6 weeks), anticipate commissioning new fridges week of 6th April. 16/04/2015 - 8 new fridges installed and commissioned, 1 inflatable fridge will be returned end of April, 1 inflatable fridge will remain in situ.
Should	3	Outpatients	Responsive	Review appointment arrangements to ensure that appointments are not booked at unsuitable times or clinics overbooked in error.	1. Review current Outpatients systems and processes and devise detailed improvement plan. 2. Clinic profiles being reviewed to ensure slots available at suitable times or any special requirements for certain slots. 3. Review capacity and demand to ensure suitable capacity so over booking minimal.	OPD Improvement Plan	Sara Davenport	31/12/2014	16/04/2015	G	with exception of Urology and Colorectal (which have both seen significant increases in 2 week referrals), Trust is consistantly hitting 2 week cancer wait targets at specialty level as well as composite trust level. Continue to consistently hit RTT but patients are getting appointemtns within 8 weeks except for endocrinology. Trust has initiated email address for patients to cancel and amend clinic appointments. Additional staff available to call centre = 90% of calls currently answered within 30 seconds. Short nitce clinics prohibited (except for 2 week cancer target patients). All clinics now require 2 weeks notice for patients. Waiting list initiatives enable provision of weekend clinics. OPD Transformation Board will continue to monitor ongoing actions.
Should	3	Outpatients	Responsive	Review the waiting areas in outpatient clinics, particularly the eye, fracture and urology clinics at busy times to prevent people having to stand while waiting.	1. Model numbers of patients attending clinics in those areas. 2. Review waiting room and seating capacity. 3. Adjust clinics or add seating if demand outstrips capacity. 4. Review timeliness of clinic start and finish times. 5. Measure waiting times in clinics.	OPD Improvement Plan	Sara Davenport	31/12/2014	31/03/2015	G	1-3. No work has been done on this. 4.Clinic start and finish times are recorded but not clear where this information is collated. 5. No work collected on clinic start times. Key risk: insufficient OPD staff to support additional work in addition to booking appointments and booking patients in. 21/01/15 OP Reception staff provided some observations but lack of information about pressure points. Paper outlining needs to additional reception staff submitted. 17/03/2015 - additional seating and furniture installed in Clinic 4 following the relocation of AMU and Day Hospital to Pymmes.

Should	3	Outpatients	Responsive	Review follow-up outpatient appointment arrangements to increase capacity to organise follow-up appointments in some of the outpatient clinics. This includes dietician, nephrology, paediatric urology and hepatology clinics where no appointments were available within 5 weeks.	1. Review and if necessary revise Standard Operating Procedures (SOPs) for follow up appointments as part of OPD improvement plan. 2. Review current appointment availability for dietician, nephrology, paediatric urology and hepatology and develop plans with services to reduce to 5 weeks where necessary. 3. Establish Standard Operating Procedures for reviewing slot availability /utilisation rates and escalation process where exceed agreed availability. 4. Review new to follow up ratios and meet best practice. 5. Review and implement Access policy re DNAs 6. Named services review and plan capacity and demand to enable routine follow ups within 5 weeks.	OPD Improvement Plan	Sara Davenport	31/12/2014	16/04/2015	G	with exception of Urology and Colorectal (which have both seen significant increases in 2 week referrals), Trust is consistantly hitting 2 week cancer wait targets at specialty level as well as composite trust level. Continue to consistently hit RTT but patients are getting appointemtns within 8 weeks except for endocrinology. Trust has initiated email address for patients to cancel and amend clinic appointments. Additional staff available to call centre = 90% of calls currently answered within 30 seconds. Short nitce clinics prohibited (except for 2 week cancer target patients). All clinics now require 2 weeks notice for patients. Waiting list initiatives enable provision of weekend clinics. OPD Transformation Board will continue to monitor ongoing actions.
Should	3	Outpatients	Well-led	Improve communication with outpatient staff and their involvement in the development of the service to ensure service vision and values are understood and fully supported by staff. Allow staff increase opportunity to express their concerns related to developments within the trust and how this affects their day to day work.	1. Arrange regular local meetings and 1-1 supervision meetings for all OP staff to ensure they are briefed on trust's vision and values and opportunity for them to raise issues of concern. 2. Ensure appraisals for all staff so individuals understand their role in delivering service and any training needs are identified. 3. Facilitate liaison between specialties and relevant outpatient staff to ensure sharing of information on specialty and future developments, encourage better relationships and communication. 4. Establish Out-Patient Delivery Group with attendance from service management and OutPatient staff to encourage better communication and resolution of operational issues.	OPD Improvement Plan	Sara Davenport	31/12/2014	31/12/2014	G	1. Regular meetings established with Registration staff. Need to arrange for OP and HR staff. 3. 21/01/15 Regular meetings taking place open to OPD staff.
Should	3	End of Life Care	Safe	Improve training for junior doctors on palliative care	1. Add Palliative Care training session to FY and CT training programme and deliver sessions every six months. 2. Add Palliative Care to mandatory training requirements for relevant staff groups	Training records	Dr Hagena (Consultant Palliative Care)	From 30/09/2014	19/01/2015	G	Palliative care education now included in Junior Doctor induction. 2 Grand Round presentations completed. Copies of training presentation received.
Must	4	Trustwide	Well-led	Take action to improve its training - both mandatory and non-mandatory - and its recording and administration of training records and training renewal requirements	1. Agree recovery plan and trajectories to deliver 80% compliance with statutory and mandatory compliance by December 2014. 2. Deliver 80% with statutory and mandatory training compliance by December 2014 3. Implement actio nplan in response to Compliance Action in inspection report.	1. Statutory and Mandatory Training Recovery plan 2. Monthly CBU performance against Statutory and Mandatory Training KPIs	1. Stanley Okolo 2. All CBU Management Teams	1. 30/08/2014 2. 31/12/2018	1. 29/08/2014 2. 17/03/2015	G	Trustwide = 80.1% CBU4 = 82.1% 08/04/2015 ongoing performance to be monitored via Performance Management Framework
Should	4	Surgery	Safe	Improve medical recording to remove anomalies and inconsistencies in records, paying particular attention to elderly care wards and take steps to improve the security of records in Surgery	Audit to be undertaken by the CBU governance coordinator with regard to health record security in CBU led wards and theatres	Audit report by clinical governance coordinator and minutes of the clinical lead meeting / emails to clinicians.	Mr Fafemi	31-Jan-15	17/03/2015	G	Medical notes audits being routinely completed in surgical areas.
Must	5	Trustwide	Well-led	Take action to improve its training - both mandatory and non-mandatory - and its recording and administration of training records and training renewal requirements	1. Agree recovery plan and trajectories to deliver 80% compliance with statutory and mandatory compliance by December 2014. 2. Deliver 80% with statutory and mandatory training compliance by December 2014 3. Implement action plan in response to Compliance Action in inspection report.	1. Statutory and Mandatory Training Recovery plan 2. Monthly CBU performance against Statutory and Mandatory Training KPIs	1. Stanley Okolo 2. All CBU Management Teams	1. 30/08/2014 2. 31/12/2019	1. 29/08/2014 2. Ongoing	G	Trustwide performance = 80.1% CBU5 = 77.1% 08/04/2015 Ongoing performance to be monitored via performance management framework.

Should	5	Maternity	Effective	Review and implement a system for updating national guidelines in maternity and palliative care	Review and update expired clinical guidelines in Maternity	Revised guidelines available on intranet.	Gary Slevin & Bio Fakokunde	31/03/2015	20/04/2015	G	10 October 2014: Action plan for revision and updating of maternity clinical guidelines attached. 11.11 14: work in progress - revised action plan sent through. (54/102 currently under review or will be reviewed) review exercise due to be completed 5/1/15. 10/02/2015 51/102 currently under review or will be reviewed anticipated completion date 31/03/2015. Slippage in delivery due to Research & Practice Development Midwife acting up as HoM until January 2015 17/03/2015 guidelines review prcoess in progress, 25/102 guidelines remain outstanding. Anticipate completion 31/03/2015 16/04/2015 - 12 guidelines outstanding to be approved at guidelines meeting 20/04/2015.
Should	5	Maternity	Safe	Improve access to records for community midwives	1. Review existing process for pulling notes for booking appointments for women who have previously delivered. 2. Hospital transport will take them to agreed locations within community settings each day eg Tynemouth Rd 3. CMW will also be responsible for collecting health records from agreed locations 4. Cost benefit analysis of ipads and digital pens for electronic recording of all care at point of contact	1. Audit number of times health records available at booking appointments NB interdependency with hospital transport and CBU3 capacity for pulling health records for all booking appointments 2. Decide re benefit of remote electronic access in all comm settings versus slight delay in recording on on site electronic system	HoM Janet Pardo/Comm Matron Service Manager for W+Cs	1. 30/09/2014 2. 30/10/2014	1/11/2014 11/11/2014	G	1. ongoing via DATIX reporting - CBU3 to review resources in main file room 2 +3. MW to start their day on site to collect records if transport not available 4.Cost benefit analysis complete completed 1 Oct 2014 10 October 2014: This action has been completed for CBU5 - there is an inderdepency with CBU3 for pulling of notes from main file - the SOP state 48 hrs notification of ntoes for clinic - CBU5 has committed to informain main file 7 days in advance of all clinics - see attached for cost/benefit of IT solution 11/11/14: no further updates
Should	5	Maternity	Safe	Improve the recording of care on the labour ward.	1. Working Party is in place to devise bespoke maternity hand held notes to reflect needs of local population in conjunction with Whittington Health. 2 new notes will include MOEWs charts, care plans with time-managed reviews, SBAR tools - these will be available throughout the pregnancy continuum 3. notes will be launched with training days on what good documentation looks like	1. SoM team to audit documentation 2. Mandatory training to include record keeping and documentation 3. staff handovers and Burning Issues to include reminders on completing all sections of the records	SoM Team HoM/Dep HoM Louisa Griffiths All MW and Obstetricians	1. immediate and ongoing 2. final version of new notes 31/12/2014	16/04/2015	G	10 October 2014: Mock set of notes ready for circulation and comment by maternity, DQ, informatics, coding team prior to wider stakeholder comments. 11.11.14: Dep HoM to take forward - revisions and comments 16/04/2015 - separate pregnancy and birth notes merged into single perinatal notes document which has been in use for bookings since December. 3 monthly maternity documentation audits ongoing.

Should	5	Paediatrics	Safe	Review the heavy reliance on agency staff use to a 20% shortage of paediatric nurses in the neonatal unit.	1. Bespoke recruitment initiatives are in place alongside NHS Jobs recruitment 2. Current students are being interviewed for starting on completion of training 3. B5 nurses are being promoted to hard to fill B6 posts 4. Aim is to reduce vacancy rate to 5% by December with ongoing recruitment using NHS jobs and OS nurses if required - plan in place to utilise proprosal from Team 24 if vacancy rate remains high 5. Recruitment bonus/help with relocation etc	1. Workforce planning action plan to be drafted 2. Monitor of completion at CBU PSSQ meetings monthly	Janet Broughton Managing Director W+Cs	End February 2015	1. Worforce action plan completed - see comment column 2. End February 2015 3. 16/04/2015 - ongoing	**G**	10 October: Hybrid staffing model devised and agreed by Execs in September 2014 1.Focus on addressing difficult to recruit B6 QIS NNU nurses • Increase B7 by 2.0 wte • Reduce B6 by 2.0 wte • Move 2 senior B5 into B6 posts on a competency framework for 6 months staff identified • Recruit into easier to fill B5 and B7 posts • Additional B7 posts will enable an integrated community team to develop • Recruit into B4 post as a rotational Nursery Nurse for Transitional Care • B6 + B7 posts out to advert • 5.6 wte new starters will be in post in Nov/Dec/Jan – this will leave 7.4 wte nursing vacancies – x2 at B7 and x5.5 at B5 17/03/2015 B7 community post interviews arranged following withdrawal of previous candidate, 2 B6 appointed, to start in May, 1 in July, 1 B5 currently undertaking B6 competency programme to be appointable in April. Due to retirement and internal promotions, there are currently 8WTE vancancies, interviews planned for April and May. Ongoing monitoring via Performance Management Framework.