CQC – Progress against 'Must Do's'

No.	CQC 'Must Do's'	Completion Date	Completion Due Date	Comment
1	Ensure that medical records are kept securely, and records can be located and accessed promptly when needed to appropriately inform the care and treatment of patients		End Jan 15 (security) End March 15 (availability) End July 15 (quality)	Significant improvement in availability in outpatients completed. Business Case for RFID tagging developed Security audits completed. 3 areas high risk in security – being actioned Quality audit findings being finalised
2	Maintain the privacy & dignity of patients placed in the observation bay in the A&E department	November 14		New bay open
3	Ensure the design & layout of the emergency dept protects patients & staff against the risks associated with unsafe or suitable premises		End Jan 15	Implementation of Ambulatory Centre for GP expected & ambulatory patients. Business Case for Urgent Care floor being developed for longer term.
4	Take appropriate steps to ensure that at all times there are sufficient numbers of suitably qualified skilled & experienced staff employed to care for patients' needs and safeguard their health, safety & welfare	Ongoing programme of work		Sufficient levels of staff in place but high use of agency in some areas due to recruitment difficulties
5	Accurately complete ' Do not attempt DNA CPR forms, and document the discussions about end of life care with patients		March 15	Jan audit being finalised. Testing practice during Feb/March
6	Take proper steps to ensure that each patient is protected against the risks of receiving care or treatment that is inappropriate or unsafe by planning the delivery of care & appropriate treatment meet the patients individual needs & have procedures in place to deal with emergencies which are reasonably expected to arise: Never Events Consent		 April 15 March 15	 Programme of work in place. Last Never Event Dec 14. Programme of work to standardise documentation & update patient information material
7	Review the ICU capacity across the Trust; employ suitably qualified, skilled & experienced staff; have the necessary equipment available to care for patients who require intensive or high dependency care	Dec 14		Additional staff recruited. Safe staffing / mitigation in place to manage 13 beds at 85% occupancy
8	Ensure that planning & delivery of care meets patients' individual needs, and ensure the safety & welfare of all patients Appointments - Rescheduling / cancellations		 May 15	 Currently 11% against target of 9%.

Summary as at 2nd March 2015

CQC – Progress against 'Must Do's'

	Pre-assessment – staffing & pathway process Diagnostics equipment availability Dementia Training	 Ongoing	April 15 March 15	Additional staff appointed. Process under review. Procurement of PACS/Order Comms underway. Additional equipment signed off. RIS being upgraded. 76% staff received level 1 training by Jan 15 (target was 75%)
9	Increase staff knowledge of DOLs and the Mental Capacity Act through necessary training to improve safeguarding		March 15	89% staff trained at basic level. 85% trained at specialist level (target is 85% by March 15) New assessment form implemented Jan 15
10	Improve contemporaneous record keeping by all staff to avoid misplacing records of care and observations Secure storage of notes & Accessibility of notes Quality / Content of notes		 Jan 15 / Mar 15 Jul 15	 As per 1. Above January audit completed. Findings being finalised. Overall improvement.
11	Ensure the staffing levels and admission criteria in the Rushey Midwife led unit is maintained to ensure safe care is provided to all women	Complete	Mar 15	2 rooms closed on Rushey to mitigate risk and ensure safe staffing levels. Interim review of staffing skill mix and requirements completed Dec 14. Birthrate Plus review completed
12	Ensure that at all times there is a sufficient number of suitably qualified, skilled and experienced staff employed to provide safe midwifery care in all areas.		Mar 15	Adjustment made to job plans to ensure provision for weekend ward review in place. External review implemented with clear recommendations & action plan developed. Exec approval given for 2 additional obstetric consultants. Birthrate Plus review completed
13	Take action to improve the ventilation system on the delivery suite, top protect patients & others who may be at risk from the use of unsafe equipment.		Mar 15	New ventilation system on track to be installed by March. Entonox monitoring being reported weekly.

Summary as at 2nd March 2015

CQC Action Plan

	CQC Regulation	Compliance Issue / CQC 'MUST DO'	Exec Lead	Critical Milestones	Complete?	Assurance	RAG rating	Est. Date of Compliance
		Incidence of never events	LB	Development of Theatre Patient Safety Strategy	Y	300 Harm Free days since last Never Event *(definition of 'Harm Free' as per national guidance)*	RED	Apr 15 (to be reviewed)
				Coaching / training programme for surgeons / theatre staff. 64% theatre staff have completed Human Factors Training (target 90% by Mar 2015)	N			
				Education programme to raise awareness of Never Events /SI and process for reporting with staff in theatres	Y			
				Learning from Incidents & Never Events presentation developed & cascaded trust wide to raise awareness amongst all staff (will test through Peer Group Review Jan / Feb 2015)	Y			
				Implement WHO patient safety curriculum & incident report scenario pilot to improve doctors awareness (first module 11th Feb 2015)	Y			
				70 harm free days (effective 19/02/15). Forecasting 73% of theatre staff to have completed HF training by end March. 89% of orthopedic team have completed training to date.				
		Access to Patient Information – including access to Translation Services	CAi	Walk about visits to include review of 8 specific Patient Information leaflets to be available on each ward (due end Feb 15)	N	Visibility of information through audit & walkabouts Patient feedback	GREEN	Jan 15
				Patient Information posters to be developed and introduced in all patient areas (to be tested)	Y			
				New statement in 4 alternative languages to be included within Patient area on Trust website	Y			
				Complaint information leaflets to be translated into top 3 languages & uploaded onto website	Y			
				Staff awareness for accessing translation services tested via Intranet survey	Y			
				Improved access to Patient Information – to be tested to provide assurance of compliance				
		Improved Signage	PH	Task group to be set up to review requirements & actions	Y	Patient & staff feedback	AMBER	Apr 15

Summary as at 2nd March 2015

CQC Action Plan

				Remove non-approved signage – 65 signs removed, others updated.	Y			
				Independent site survey by Parsons Brinkerhoff leading to recommendations that would achieve compliance for the site according to NHS Way finders	Y			
				Solutions to be identified for future signage	Y			
				Survey Monkey to gain staff views on 3 proposed signage options as well as face to face engagement - underway	N			
		Estates – storage	PH	Review of all storage issues trust wide to be undertaken	N	Patient & staff feedback via surveys / walk around visits	RED	June 15
				Priority areas to be agreed and plans developed	N			
				Daily walkthroughs to ensure corridors remain uncluttered by taking corrective action as required (taking place at 3 & 4pm each day)	Y			
				Create theatre storage area. Feasibility study underway (Completes 1st week April). Business Case to be written by end Apr 15)	N			
				Offsite storage facility to be established. (Business Case developed & presented to Planned Care Board Feb 15, to be presented to Business Case Group – Mar 15) Implemented June 15	N			
				Implement central logistics team to reduce volume of deliveries each day (7 day working central logistics team proposal Feb 15, implemented April 15)	N			
				'Clear the clutter' campaigns held regularly (next one due by 25 Feb 15)	N			
		Cleaning – standards of cleaning required on some wards / areas	PH	Weekly audit of Very high risk areas and monthly audit of high risk areas to ensure compliant standards are maintained	Y	Patient feedback Exec / staff walkabouts /audit	RED	End Jan 15
				Work underway to further improve the process with increased engagement with ward staff				
		Lack of ITU capacity	SE	Appointment of 1 additional consultant to ensure appropriate staffing levels in place Mon - Fri	Y	Good outcomes on INARC 85% occupancy levels	GREEN	Dec 14
				Appointment of 2 additional junior doctors to meet ITU standard of 1:8 - 2 working at night	Y			
				Capacity managers to meet with lead nurse ITU every morning to prioritise bed allocation & ensure availability of 1 level 3 bed in the Trust	Y			

CQC Action Plan

				April 2015 budget to be established to meet staffing against core standards (Business Case submitted to CCG as part of contracting round)	N			
				Currently running with sufficient staff to manage 13 beds at 85% occupancy. Mitigation in place to ensure safe staffing of patients. Previous Business Case being updated to review range of options going forward for 'Urgent Care Floor' (end Jan 2015)				
		RTT performance not being met	BB	Training Manager recruited (started Nov) and revised training programme to be implemented trust wide (Dec)	Y	Achievement of RTT performance	RED	Mar 15 (Aggregate perf)
				Interim Access Manager in place. Substantive appointment made – starts end March.	Y			
				The Trust will return to reporting January performance against all 3 standards and will submit to UNIFY in February.	N			
				Substantive recruitment of a central 18 weeks team is pending completion of the Trust Clinical Administration Review in June. External validation resource has been secured for the additional period to mitigate against risk.	N			
				Service redesign to be implemented in non compliant specialties - ongoing	Y			
				The current unvalidated position is: 82% Incomplete , 63% Admitted, 85% Non-Admitted				
		High level of appointment re-scheduling / cancellations by the Trust	BB	Audit to be carried out to understand variation & reasons for re-scheduling / cancellations	Y	Level of cancellations / rescheduling 9% or less Patient feedback	AMBER	May 15
				Criteria for exclusion identified & data cleansed	Y			
				Priority specialties identified & action plan developed. Current focus on paediatrics, ENT, ophthalmology, orthodontics, plastic surgery, dermatology, endocrinology, haematology (ongoing)	N			
				Last position reported - 11% trust wide against target of 9%				
		Low awareness of MCA and DOLs across the Trust	CAi	Develop standardised assessment document for MCA (document launched Jan 15)	Y	Good level of awareness of DOLs & MCA from staff evidenced from documentation	GREEN	Mar 15
				Training of Junior Doctor workforce & use of new standard documentation (Feb 15 onwards)	Y			
				Training developed & multi-professional training programme to run through summer 2015	N			

				Additional MCA & DoLs training to be included at Trust induction for new staff	Y			
				Currently 89% staff have been trained for MCA & DoLs (level 1) **Specialist DoLs training – 91% trained (target 85% by March 15)**				
		Low use of care bundles. Care plans not always in place, patients not always involved in their care plans	CAi	Develop & launch revised ward dashboard to include care bundle completion audit by October 2014	Y	Documentation to evidence good use of Care Bundles / Plans	AMBER	Mar 15 (to be reviewed)
				Implement revised process for review, updating and sign off of new Care Pathways - complete	Y			
				Immediate review of existing Care Bundles & their usage to identify gaps / areas of concern to action.	Y			
				QI team to systematically review care bundles in place to ensure evidence base, content & format are consistent with good practice (see below for current position)	Y			
				Include within Practice Educators ward based teaching sessions	N			
				Process for use of Care Pathways redesigned & being implemented. Improvement Project in place for Care Bundles. **Progress to date: 1 bundle complete, 2 bundles content agreed – awaiting reformatting, 1 bundle being simulation tested, 6 bundles being drafted, 1 bundle no start, 2 bundles withdrawn**				
		Patients with dementia placed on inappropriate wards placing them at risk due to inadequate staff training and levels on these wards to care for dementia patients	LB	Appoint interface geriatricians to take lead role on medical wards & surgical liaison outreach role appointed for surgical wards	Y	Reduction in dementia patients in outlier wards Evidence of staff training & awareness Matrons Rounding to monitor compliance	AMBER	Jan 2015
				Relevant front line staff to undertake dementia training. Achieved HEE target of 75% trained by Dec 14. The next target is 80% of staff trained by end Mar 15.	Y			
				Training for junior doctors to be re-instated at induction	Y			
				Professor of Dementia to be appointed – post currently being re-advertised	N			
				Audit to be undertaken to test training levels & impact of 'Care Crew' (12 month review March 15)	N			
				HETV confirmation received that the Trust has met target of 75% Tier 1 training (only Trust within Thames Valley to do so). The next target is 80% of staff trained by end Mar 15. Funding secured to recruit dedicated trainer.				

		Medicines Management – lack of secure storage / fridge temperatures not checked / compliant	LB	Audit to be undertaken to identify issues (audit May 2014) Immediate action taken to address non compliant areas.	Y	Audit to demonstrate compliance	AMBER	Jan 15
				Process to be implemented to monitor ongoing compliance (twice yearly trust wide audit process in place)	Y			
				New min-max thermometers implemented trust wide (on order – expect to complete implementation Dec 2014)	Y			
				Training of all band 6 pharmacists to be completed, to roll out training to all ward staff (starting Dec 2014)	N			
				Actions taken. 3 non compliant areas remaining (equipment on order) Risk assessments carried out in meantime. Further audit completed February 15 – non compliant areas being addressed				
		Medicines Management – Under reporting of medication errors as incidents	LB	Implementation of Medication Safety Committee (first meeting held in November 2014)	Y	5% Increase in rate of reporting / reduction in serious incidents / harm on wards over next 6 months (from Oct 14)	RED	Apr 15
				Review of reporting errors & themes to be completed	Y			
				Education & training programme to be rolled out trust wide – Patient safety newsletters and 'hot topics' commenced	Y			
				Reporting of medication errors as incidents added to patient safety thermometer	Y			
				Process to be implemented for continual feedback & learning to staff – currently being reviewed	N			
				Rate of reporting currently showing no improvement as yet– 84 reported errors in January (versus target of 128 per month)				
2	**Treatment of disease, disorder or injury Diagnostics & Screening** The registered person had not ensured that **equipment was properly maintained & available in sufficient quantities** in order to ensure the safety	Out-dated Radiology Information System (RIS)/PACs system	SE	Upgrade to Radnet completed (Mar 15)	N	Fit for purpose RIS in place/data quality issues addressed PACS installed in timeframe	AMBER	Mar 15 (RIS upgrade) Nov 15 (PACs)
				PACS specification completed	Y			
				Procurement process completed (Mar 15)	N			
				New PACs system installed (Nov 15)	N			
		Trust wide equipment – central inventory, 5 year replacement	PM	Central inventory and ward inventory in place	Y	Inventory in place and current. 5 year programme	AMBER	Jan 15
				5 year replacement programme in place – currently frozen due to financial pressures	Y			

	of service users & meet their assessed needs.	programme, response times for requests		Individual ward access to inventory / replacement programme / suppliers (end Dec 2014)	N	signed off		
				Process implemented for rolling training programme	Y			
				New Call Log System to be implemented to improve response times to maintenance requests (Sept 2015)	N			
				New labeling system to be implemented (end Dec 2014) – ad hoc roll out started	N			
				Staff trained & aware of process to escalate equipment issues	Y			
				Peer Review Group testing actions embedded to provide assurance - to take place in Mar 2015				
3	**Treatment of disease, disorder or injury** The registered person had not, so far as reasonably practical, made suitable arrangements to ensure the **privacy & dignity of** service users.	Lack of accurate and consistent completion of DNA CPR forms across the organisation *(specifically completion of review date, and signatures from consultant)*	LB	Medical Advance Plan to be included within initial patient assessment	Y	Audit to demonstrate compliance to forms completed and filed correctly within notes	AMBER	Mar 2015
				Update mandatory training requirements following recommendations from CQC inspection	Y			
				Completion of trust wide audit to identify baseline & non compliance (July audit – 80% decision discussed with patient / carer)	Y			
				Education & Training programme to be developed & rolled out to clinical workforce	Y			
				Clinical leads instructed to discuss importance of DNACPR processes at January Clinical Governance meetings	Y			
				Re-audit to be completed to assess improvement – results expected by end February 15	Y			
				Review date – Trust following South Central Policy (which states that review date NOT mandatory) Re-audit completed – testing through Peer Review process in March				
		Mixed sex ward sleeping breaches in WBCH	PM	Plans to mitigate issue to be received (18th Dec 14)	Y	No mixed sex breaches trust wide	AMBER	Apr 15
				Basic principles & design of plan agreed	Y			
				Detailed plans drafted with architects (Feb 15) - underway	N			
				Sign off of plans & costs by West Berks, Planned Care & Exec (Mar 15)	N			
				Building works to be completed	N			

				Plans for WBCH now developed – sign off due in March. Mitigation in place in the meantime.				
		Patients with dementia subject to multiple moves often at night causing distress and anxiety	LB/SE	Care Bundle & Forget-me-not scheme to be implemented (Forget-me-not scheme launched 18th November 14 – roll out to complete end Jan 14)	N	Reduction in night moves. Patient feedback.	AMBER	Jan 15
				Algorithm for bed managers to be developed & implemented - algorithm completed – now being rolled out	Y			
4	**Treatment of disease, disorder or injury** **Maternity & Midwifery** The registered provider must ensure service users are protected against the risks associated with **unsafe or suitable premises by means of suitable design & layout & adequate maintenance** of the premises in connection with regulated activity	Labour ward has insufficient scavenging system to remove used nitrous oxide from the air produced from patients when using entonox.	SE	Procurement process completed	Y	Fit for purpose ventilation system in place. Compliance with entonox levels	AMBER	Mar 15
				Planning permission granted (building work currently underway)	Y			
				Delivery of Air Handling Unit complete (30th Nov 14)	Y			
				Completion of internal installation and system commissioning (due March 2015) May be slippage – assessing currently	N			
				Weekly monitoring of Entonox levels in place with escalation process	Y			
5	**Treatment of disease, disorder or injury** **Surgical Procedures** **Maternity & Midwifery** The provider did not have suitable arrangements in place for **obtaining & acting in accordance with the consent of service users** in relation to the care & treatment	Consent practice varied across the Trust causing operating lists to be changed on the day of operation	PM	Audit of current consent practice to be completed	Y	Audit to demonstrate good consent processes in place with documentation on notes to provide evidence that we are acting in accordance with patient's wishes.	AMBER	Mar 15
				Audit of patients to understand views re engagement in consent process (Due 20/02/2015)	N			
				Development & implementation of standardised documentation including patient information leaflets (Dec – Feb) – underway and on track	N			
				Letter to all consultants to launch Programme of work and to remind them of importance of consenting correctly (12th January 2015)	Y			
				Presentation given to each Clinical Governance group to launch programme of work and to discuss importance of consent (practice & process)	Y			
				Re- audit to evidence improvement – both internal practice & patient views (July 2015)	N			
				Consent practice audit completed. Patient audit to be conducted in week beginning 16/02/15. Consultants providing input into the design of the consent education and training programme.				

6	**Treatment of disease, disorder or injury Surgical Procedures Maternity & Midwifery** The provider had not taken appropriate steps to ensure that at all times there were **sufficient numbers of suitably qualified & experienced persons** employed for the purpose of carrying on the regulated activity	Staffing shortages for registered nurses and healthcare assistants on surgical wards and within radiology	CAi	Complete trust wide skill mix review. To be presented to Board in March 2015	Y	Evidence to show sufficient numbers of suitably qualified nursing staff in every area to provide a safe service,	AMBER	Mar 15
				New process implemented – DoN of the Day – operational management of day to day staffing trust wide	Y			
				Rag Rated system to be implemented to provide trust wide oversight of staffing in real time - shift patterns & hotspots – 7 day cover reports provided every Monday & Friday, accompanied by NHSP Shift Reports	Y			
				Development & implementation of rules for good rostering. Guidance has been completed and circulated.	Y			
				Development & implementation of Policy for good rostering – draft completed, and timetabled for consideration at next JSCC meeting	N			
				Implementation of 12 hour shifts where appropriate (To be completed in Planned Care in April 15)	Y			
				Increase in HCA crew resource to support 1:1 care. Business case presented. To be amended and re-presented in Feb 15	N			
				Development & implementation of Recruitment & Retention Strategy. Smooth move and refer and friend schemes also in place.	Y			
				Currently 212 qualified & midwifery vacancies – 74 conditional offers made (includes theatre practitioners). Currently 80 HCA vacancies – 24 conditional offers made Recruitment team to visit Portugal in April 2015				
		Shortages in medical staffing, weekend cover, use of locums, rotas etc	LB	Complete review of medical cover for every ward trust wide, including rotas, out of hours cover and use of locums	N	Evidence to show sufficient numbers of suitably qualified medical staff in every area including weekend cover to provide a safe service,	AMBER	Mar 15
				Develop & implement plan to address shortages, if required	N			
				August intake – increase staffing by an additional medical registrar- 17.00-23.00, additional medical SHO in the hospital at night team, and additional weekend medical SHO				
		Staff shortages in Surgical Pre-Assessment Unit led to assessments being held	PM	Appointment of senior nurse lead	Y	Audit to demonstrate all pre op assessments undertaken at least 4 weeks prior to surgery	RED	Apr 15
				Development & implementation of a plan to redesign the pre-assessment booking process.	N			

		less than 4 weeks prior to surgery and on occasion caused operations to be cancelled		Audit of planned operations to review impact of change	N			
		Midwifery staffing ratios in the Rushey Midwife Unit below guidelines & staffing shortages in the general maternity service	SE	Closure of 2 rooms on Rushey to mitigate risk & ensure safe staffing levels. Use of 4th room being changed.	Y	Appropriate ratio of midwives to births	AMBER	Mar 15
				Business Case to Exec for sign off to increase overall midwifery staffing levels to achieve National Standard of 1:28 (not approved – awaiting outcome of Birth Rate Plus Review)	Y			
				Implementation of Birthrate Plus tool to inform required staffing levels (completed)	Y			
				Prior to completion of Birthrate Plus – interim review of staffing skill mix & requirements (by 5th Dec 14)	Y			
				Daily meeting to be instigated to review activity & staffing across the service over following 24 hours & redeploy as necessary	Y			
		Consultant obstetric presence not in line with national standards Dedicated consultant anaesthetic cover required 50 hours per week Consultants did not routinely visit wards at weekends within Maternity	SE	Adjustment to job plans to ensure provision for weekend ward review in place	Y	Consultant presence in place, including out of hours, to ensure the service is safe for patients	AMBER	Mar 15
				External review implemented with clear recommendations & action plan developed	Y			
				Business Case to be taken to Exec for sign off for additional obstetric & anaesthetic consultant cover (obstetric cover approved – anaesthetic cover on hold awaiting trust wide review	Y			
				Trust wide Review of current medical staff across anaesthetics	N			
				Exec approval given for 2 additional obstetric consultants Business Case for additional midwives & additional anaesthetic on hold until result of Birthrate plus & trust wide review completed				
7	**Medical Records** Service users were not protected against the risk of unsafe or inappropriate care & treatment arising from the **lack of proper information about them**	Secure storage of notes	BB	Trust wide review of storage & security issues completed – 3 high risk areas identified & being actioned	Y	No security / storage issues across the Trust	AMBER	Jan 2015
		Accessibility of notes	BB	Completion of diagnostic stage to understand issues impacting on availability	Y	98% of all medical records available at the time of appointment / admission as inpatient	AMBER	Mar 15
				Development & implementation of re- training & education programme trust wide (October 14 – March 15)	Y			

	by means of the **maintenance of: an accurate record in respect of each service user** which shall include appropriate information & documents in relation to the care & treatment provided. The registered provider must **ensure that records are kept securely & can be located promptly when required.**			Changes implemented to delivery for outpatient clinics	Y			
				Changes implemented within EPR to enable automatic requesting of records for emergency admissions	N			
				Audit process to be developed & implemented to enable monitoring of compliance for tracking records	N			
				Investigate alternative location for MR function to reduce need for offsite storage – Business case now being written	N			
				Investigation into alternative IT solution, including the electronic tagging of paper records (IFiT) solution within MR function to enable improved storage & pulling of notes – Business Case written & being reviewed	Y			
		Content of notes	BB	Completion of diagnostic stage to understand issues - Undertake audit and create action plan based on 2014 audit output (Dec 2014 - Feb 2015) – audit complete - initial findings being reviewed	Y	Audit using National criteria to demonstrate compliance against criteria of at least 85% (criteria % required for compliance)	AMBER	Jul 15
				Actions to be taken in areas of non compliance (Feb – July)	Y			
				Dec 14 audit showed of 19 criteria reviewed, 11 areas have shown improvement, 4 areas have not, 2 areas were new criteria this year, and 2 areas still being reviewed. A total of 8 areas of non compliance are now to be actioned.				
		Lack of functioning / available IT equipment in clinical areas	HA	Service Improvement Plan created with CSC that identifies and plans to resolve issues with the use of the IT Helpdesk	Y		RED	
				Conduct full audit of all clinical areas - 11 departments completed to date. New role established on 16th February to complete a full audit over 3 months.	N			
				Identify lead IT contact for each clinical area and ensure they are appropriately trained in escalation process – currently 80% complete.	N			
				Upgrade 3000 computers to improve functionality and compatibility at a rate of 300 per month – target 1500 by May 2015 (Feb 2015 – 600 completed)	N			
		Inconsistency in recording of clinical information across wards	HA	Review of mobile devices across the Trust to ensure they are available for use – within audit - underway	N		AMBER	
				Review of existing SOPs and non compliance	Y			

		EDL not completed within target timescale	HA	Update to facilitate auto population of EDL from Cerner (on hold for finance)	N		AMBER	
				Setting altered to prevent a discharge note being raised unless the patient is on EPR	Y			
		Delays in sending GP letters following outpatient appointments	BB	Clinical Admin Review Programme to align services along the patient pathway, and redesign the clinical administration for the hospital – programme underway	Y		AMBER	
		Inconsistency in recording early warning scores electronically and in paper notes	HA	Review of existing SOPs	Y		AMBER	
				Development of a system to enable auditing/ reporting at ward level – Ward accreditation audit	Y			
		Outliers experiencing repeated tests due to lack of system to record earlier tests	HA	Approval of funding obtained nationally for implementation of Order Comms	Y		AMBER	
				Roll out across the Trust (pathology & radiology)	Y			

Rag Rating criteria:

GREEN	Actions taken – issue addressed
AMBER	Actions being taken – progress being made against timescales agreed
RED	Actions being taken but some concern on delivery for example, timescales, or actions having little impact on outcome

Completed areas of compliance being tested

	Compliance Issue / CQC 'MUST DO'	Exec Lead	Testing mechanism	Date of testing	Outcome	Next steps
1	Staff awareness of MCA & DOLS	LB	Initial test through newly formed Trust Peer Review Process (pilot) & tested again during Jan	Dec 14 & Jan 15	Audited Jan 15. 13 wards visited (40 staff spoken to). High level of awareness amongst nursing staff – some additional training required for HCA & junior medics. Dementia related documentation not universal but is being used.	Feedback to areas of issue. Additional training being sourced via HE funding.
2	Estates – delay in response to maintenance requests	PH	Initial test through newly formed Trust Peer review Process (pilot) - & tested again during Jan	Dec 14 & Jan 15	Audited Jan 15. 13 wards visited (40 staff spoken to). Log book system in widespread use & well understood. Some positive feedback, however, most wards reporting outstanding issues. Responses that escalation process not effective & only 1 ward reported having estates 'buddy'.	Director of Nursing to discuss feedback with Dir E&F & agree improvements to process
3	Patients being kept overnight in recovery / surgery going ahead despite lack of capacity / planned ops cancelled due to lack of capacity	PM	Process embedded to monitor compliance	Oct – present (ongoing each month)	Reporting demonstrates no patients kept in recovery inappropriately – no surgery undertaken without ITU capacity	Continue to monitor through monthly performance meetings
4	Outdated equipment in main x-ray department	SE	Review of asset register / review of equipment in dept	Ongoing	Business case agreed by Exec for new equipment. Mitigation in place for areas of risk	Ongoing review by care Group
5	Issues with privacy & dignity for patients within A&E Observation Bay	SE	New Obs bay opened in Nov 14 – to be kept under review via walkabouts	Nov 14	No issues to date – to be kept under review	Under review
6	Improvement required to mortuary area	LB	Patient feedback / Peer review Group to test	Jan 15	Improvements made to patient area. Mis-understanding by CQC of area accessed by families.	Review during January
7	Patient information / translation services	CAi	Spot check on wards via walkabouts (posters) & survey via Trust intranet (staff awareness)	By end Feb 15	Testing to be undertaken	-
8	DNA CPR	LB	To be tested via Peer review Group during end Feb – mid March	By mid March		
9	Staffing (nursing & medics)	LB / CAi	To be tested via Peer review Group during end Feb – mid March	By mid March		

Summary as at 2nd March 2015

Priority Actions for February 2015

	Compliance Area	Exec Lead	Action Owner	Action to be taken in the month	Concern(s) to be addressed
1	Incidence of Never Events	LB	Tom Crawford	Completion of first module for WHO patient safety curriculum & further training of theatre staff to reach target 90% by end March	Forecasting 73% by end March vs. target 90%
2	Estates storage	PH	Phil Holmes	Proposal for central logistics team to be taken to SMT before end month. 'Clear the clutter' campaign to be held before end month.	Storage & clutter still an ongoing issue
3	Cleaning standards	CAi	Caroline Ainslie	CAi to review current processes with Head of housekeeping & ward staff to improve performance	High level cleaning issue becoming a current theme
4	High level cancellations / re-scheduling	BB	Steve Green	Update on position still outstanding and actions being taken	No update provided since December
5	Pre op assessment	PM	France Woodroffe	Meeting to be held with Pre op nurse lead & waiting list officers to agree new process – still outstanding from last month	Meeting still outstanding – no progress made
6	Care Bundles	LB	Andy Henderson	Care Bundles not currently being used to be retrieved from wards until revised bundle developed	Removal of bundles not in use
7	Medicines Management – drugs storage	LB	Claire Cartwright/DoNs	Audit complete – areas of poor practice to be addressed by Care Group DoNs	Poor practice to be addressed
8	DNA CPR	LB	Alex Baker	Peer Review Group to test current practice – to ensure accurate completion of documentation & discussions taking place appropriately	Need to test medical staff compliance
9	Consent	PM	Peter Malone	Completion of patient audit by 20th Feb. Completion of standardised documentation.	Pace of delivery
10	Staffing	LB	Sharon herring	HCA care crew resource – Business Case to be presented	To support staffing capacity for 1:1 care
11	Medical records	BB	Clive Wewerka	Quality audit findings to be completed & communicated. Security audit high risk areas to be actioned. Care groups to identify clinical & admin reps.	Pace of delivery
12	IM&T	HA	Mike Robinson	Identification of IT contact for each clinical area to be completed	Only 80% identified to date

Green = action completed

Summary as at 2nd March 2015