The Royal Wolverhampton
NHS Trust

Care Quality Commission Action Plan
4 February 2019

Agenda Item No: 11.6

Safe & Effective | Kind & Caring | Exceeding Expectation

The Royal Wolverhampton NHS Trust

Trust Board Report

Meeting Date:	4th February 19
Title:	Care Quality Commission Action plan
Executive Summary:	Following the CQC inspection report dated June 2018 an action plan has been developed to include corporate and local actions. TMC will receive the plan and progress on a quarterly basis until all actions are closed or being monitored by another sub Board Committee. Communication with Divisions has occurred and agreement regards local monitoring and reporting of action progress; and advancement toward outstanding criteria. Future reports will be managed via the Health assure, with action leads updating directly into the system. The report format will change to CQC headings of CQC must do, CQC Should do, supplementary improvement actions identified by the Trust, action leads and timescales. Actions towards outstanding will be monitored via the Divisional Quality Performance meetings and Core Service reviews and included in this report as received. See report detail below headlines and appendix 1 for all updates received since the last report. A single action plan is under-development following inspections to the following GP Practices: Alfred Squire Road Health Centre – 5/7/18 Lea Road Medical Practice – 5/7/18 Warstones Health Centre – 5/7/18 West Park Surgery – 5/7/18 Thornley Street practice 24/10/18 A Primary Care summary of findings and proposed actions along with leads and timescales is provided in Appendix 2 (please note - the summary is provided for reference and is subject to review by the Directorate and Division)
Action Requested:	**Receive and note,**
For the attention of the Board	
Assure	• Divisions are monitoring CQC compliance and actions via Quality performance meetings. • CQC action plan to be monitored at TMC until completion
Advise	• A number of actions are subject to ongoing activity/monitoring and may require an assessment of assurance to decide on closure.
Alert	• See actions highlighted in report detail below.
Author + Contact Details:	Tel 01902 698121 Email maria.arthur@nhs.net

Links to Trust Strategic Objectives	1. Create a culture of compassion, safety and quality 2. Proactively seek opportunities to develop our services 3. To have an effective and well integrated local health and care system that operates efficiently 4. Attract, retain and develop our staff, and improve employee engagement 5. Maintain financial health – Appropriate investment to patient services 6. Be in the top 25% of all key performance indicators
Resource Implications:	None
Report Data Caveats	This is a standard report using the previous month's data. It may be subject to cleansing and revision.
CQC Domains	**Safe:** patients, staff and the public are protected from abuse and avoidable harm. **Effective:** care, treatment and support achieves good outcomes, helping people maintain quality of life and is based on the best available evidence. **Caring:** staff involve and treat everyone with compassion, kindness, dignity and respect. **Responsive:** services are organised so that they meet people's needs. **Well-led:** the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.
Equality and Diversity Impact	No adverse impact on PPCs
Risks: BAF/ TRR	TRR 3644 – Failure to improve CQC Compliance gaps
Public or Private:	
Other formal bodies involved:	
References	CQC Regulations Standards
NHS Constitution:	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best Value • Accountability through local influence and scrutiny

Report Details	
1	This report provides progress against the CQC action plan last reported to TMC in Oct 18 (agreed for quarterly update). The action plan (approved at TMC in Sept 18) includes specific transactional requirements from the June 18 CQC report as well as areas for improvement added by the Trust following the inspection feedback. Appendix 1 shows previous updates received from Directorates/Divisions/Trust for context with the latest updates shown in bold text. The following are highlighted: • 1.1 Action taken to follow up mandatory training, however compliance not yet at target.(see also 1.16.2 Safeguarding training compliance continues to be a challenge) • 1.1.2 Audit completion rate is improving slowly, slightly behind completion target at Q3 (report made for Div 1 but all Divisions slightly behind target at Q3). • 1.3 Emergency trolley stock compliance – Consider closure, audits shown improvement and compliance routinely reported to Divisions and COG. • 1.4.2 Medication prescription, administration and storage – Consider closure, rolling programme of audit and escalation in place via management structures. • 1.7.2, 1.7.3 - NatSSIPs/LocSSIPs/WHO - Further to NHSI NE workshop, further

	work planned to review and standardise safety checklist. Working subgroup to be established. • 1.1.8 Poor Documentation compliance – Nursing audit review will incorporate documentation audits. Local audit plans to consider local themes/compliance gaps. Human factors expertise remains a gaps. • Item 1.9 Establish system and address triage delays in ED – progress update required • 1.1.10 MCA compliance and documentation – Routine audit in place. Further actions identified to address poor audit results. • 5.6 Information Governance actions – Band 6 resource for a further IG Officer will assist the delivery of this agenda for Trust Services. Previous Actions closed (October 18): 1.1.4 – Mixed equipment storage of clean & dirty items, this has now been addressed. 2.3 – review of elective surgical re-admission rates 2.5 – Treatment waiting times disaggregation by site to address specific issues 1.6 – Explore staffing as per Birth rate plus methodology in Maternity Actions closed in this report (Jan 19): 2.5 Treatment waiting time disaggregated by site 5.2 – Confirm Sepsis training requirements for Maternity staff Work towards outstanding (stretch target) update (Jan 19): None received

Appendices	
1	Appendix 1 CQC Action plan Appendix 2 CQC Primary Care action plan

Domain	**What does outstanding look like?**	**Gap Analysis Evidence**	**Aspiring Action Plan**				
Safe							
	Strong safety system						
	Open & transparent						
	Good reporting culture						
	Feedback is valued and acted upon consistently						
	Innovation						
	Zero harm culture						
	Analytics						
Effective							
	Holistic approach						
	Innovation						
	Engaged & motivated staff						
	Staff development						
	Performance						
	Team working						
	Information sharing						
	Audit						
Well - Led							
	Vison & values evident						
	Goals to improve outcomes						
	Review outcomes						
	Staff are motivated						
	Staff satisfaction						
	Team working						
	Innovation						
	Constructive challenge						
	Improvement evident						
Caring							
	Excellent feedback						
	Exceed expectations						
	Person centred culture						
	Team work						
	Staff go 'that extra mile'						
	Patient engagement						
Responsive							
	Individualised care - vulnerable / complex needs						
	Choice / flexibility						
	Innovation						
	Feedback						
	Access / timely response						
	Active review of complaints						

Appendix 1 CQC Action Plan

Domain	Action	Accountable lead	Timescale	Assurance group	Evidence	Stretch action	Accountable lead	Timescale	Action relating to Directorate/Division/Trust			
									Directorate	Division	Trust	Trust Lead/Assurance group
1.0 Safe												
1.1	**Improve Hand Hygiene practice consistently in Diagnostic imaging:**											
1.1.1	IP/HH mandatory training 100%.	DMT	31/05/2018	Directorate Gov Meet.	Training data				Management to review, cleanse and follow up red mandatory training. ED, Theatres, Diagnostic Imaging to address mandatory training non compliance	Division to set a 2 month improvement target for red mandatory training. Dv1 - Divisional position red 92.6%, nursing is however green at 95.5%. Dv 2 mandatory training 92.8 Dv 3 - DMT:Mandatory Training a focus of monthly performance meetings with Directorates held to account for delivery against target, divisional position is 95.55% Dv 3 - Directorates: Monthly monitoring of compliance in place. 20.12.18 Division 3 - Green for compliance of IP, HH at 94%, areas for improvement with plan notably Adult Communinity, VI and Dermatology. **Jan 19 Division 1 - Divisional position unchanged at 92%. Nursing position has deteriorated and currently at 94%. All band 7 and Matron leaders have received communication from the Head of Nursing in regards to this. Divisional Medical Director has also emailed all Clinical Directors with recent training percentages requesting support.**	Mandatory Training leads to target offers of training to poor compliance areas.	IPCG - Training SME
1.1.2	Audit practice	DMT	31/05/2018	Directorate Gov Meet.	Audit reports	Implement oversight audits			Implement local audits	Dv1 - we track divisional compliance every month at divisional governance meeting. Whilst we are 5% behind our projection currently , we are in a better position than the previous 2 years at this same time. Dv 2 - Audit compliance is reviewed at the divisional monthly governance meetings and monitoring ongoing Dv 3 - Directorates: Audits reviewed monthly and progress monitoring in place. Support from Governance as required **Jan 19 Div 1 - adjusted completion rate of 40%, expected completion rate at the end of Q3 was 47% so we are currently 7% behind plan. For the same period last year we were 11% behind plan. So in a better position this year than last year.**	Implement oversight audits - Div 3 behind trajectory. QJPP programees being introduced for medics - aid complaince	IP/IPCG
1.1.3	Maintain cleaning logs	Surgery Dir MT	31/12/2018			Dv 1 - 100% compliance with completion and assurance.	E. Lengyel, Matron		Surgery core service to monitor compliance with cleaning logs	Dv 1 - Head of Nursing to add to Matron 1:1 for discussion. Dv 2 - Monitored at 1-1 Dv 1 - Matron now has monthly assurance from each band 7 lead. Less dust at both CCH and New Cross sites now most building work is complete. Monthly audits had shown an issue with dust on Theatre trolleys underneath - this has been addressed in all Theatres apart from CCH now by employing an additional floating TSA who has cleaning as part of their daily tasks. CCH post currently out to advert. **Jan 19 - Div 1 TSAs for CCH currently on induction.**	Revised cleaning strategies approved last month - relaunched	Environmental Group
1.1.5	Review safe staffing levels	Dir MT/DMT	30/04/2018			Consider assurance regards other professional groups			Medicine and Radiology to review safe staffing levels Dv 3 - Radiology: There is an algorithm for staffing in all of the areas in Radiology. Team leaders work coherently so no area goes understaffed. There are options to close scanners or bring additional staff in on overtime should the need arise. Demand and capacity work underway which includes workforce. Review safe staffing levels- Biannual review Ongoing monitoring	Dv 1 - Medicine - Biannual skill mix currently in progress. **Jan 19 Div 1 - bi-annual inpatient skill mix review in progress plus Grant Thornton review ongoing.**	Workforce review - Nursing, Medics to inform targeted action.	HR, Associate Chief Nurse
1.2	**Ensure COSHH compliance across services**											
1.2.1	Assess COSHH compliance in wards/depts.	HSO	31/01/2018	HSSG	Audits	Environmental Audits	Margaret Simcock		Implement COSHH risk assessment and control actions - Medical core service. - H&S department will be rolling out re-education for wards and departments and recommunication of procedures (Margaret.S) **Dec 18 update – continue with education via news bulletins, safety Rep forum and H&S training programme. This forms part of the work plan for next 12 months.**	Dv 3 - Directorates: COSHH compliance part of Service Lead/Manager role. Awaiting outcome of H&S Audit to identify further actions	H&S audit programme covering COSHH to prioritise areas identified by CQC.	HSO
1.2.2	Directorates to action gaps.	DMT	31/12/2018	HSSG	Re- audits			Dec-18	Carry out local H&S, environmental inspections and follow up actions. **Jan 19 Margaret.S - GP practices within Primary Care Directorate requested to provide list of chemicals used. Once received these will be added to Trust COSHH register Due 31/1/19. Further awareness on ocmpletion of risk assessments is to beadded to the next issue of Risky Business .**	Dv 1 - Last report received August 2018 meeting for quarter 1. Reduced number of incidents from Q4 (109 to 82). Top 3 categories continue to be violence and aggression, sharps, manual handling. No RIDDOR in Q1. H&S self assessments - local returns can be challenging, currently at 25% return. Directorates being challenged by Division. CAS alerts proactively being closed via Division. Environmental reports received monthly; non-returns have been addressed by Head of Nursing. Local environmental audits in theatres done weekly plus monthly audits and communicated at leadership meeting. Dv 3 - DMT: receive/ review quarterly H&S reports at Div Gov meetings Dv 3 - Directorates: Implement actions from environmental inspections and report to Division **Jan 19 Margaret S - Some issue with local areas not updating their Health and Safety self-assessments. Slip, trip and falls increased in Q3 to 17. Top 3 issues continue to be Slip, trip and falls; Violence & agression; Sharps. There has been 1 RIDDOR reportable incident in the year to date - none in Q3.**		

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									Directorate	Division	Trust	
1.3	Emergency trolley stock complies with Policy	DMT	30/11/2018	Resus Group	Audits		Nicola Wise			Dv 1 - Division to review planned resus audit results, QRV results, NAAS results and wider discussion in regards to quality rounds and findings. Dv 1 - Most recent resus audit was discussed at governance in August; showed non-compliance for daily checks in 4 areas (A15 Theatre recovery Paeds - 2 days, WEI, Mary Jones Ward - 1 day, B9 ICCU - 3 days, A26 Fracture clinic - 1 day). No equipment missing across Division 1. No gaps in checks for the inpatient areas. No gaps in weekly checks for any area. Results discussed at Matrons 1:1s and at divisional nursing leadership meeting plus emails sent to directorates for discussion and action at their governance meetings. **Jan 19 - Div 1 nothing further to add - await results of next audit. Nothing escalated to division.**	Review arrangements, programme and frequency of resuscitation audits, how results fed back and actioned. Reaudit of non compliance, paed trolleys - 83% revisit 100%	Resus Group
1.4.1	Staff communication and training around medication incidents (Discharge lounge/A5/A9/Medical Core Services)	DMT	30/11/2018	MMG	E mails / Training records / Alert notices	Medication Safety Officer to attend all Div Gov meetings	Alison Tennant			Dv 1 - Division requested Medication Safety Officer to attend Governance meeting to discuss concerns regarding increased reporting from General Surgery. Officer reported that these were no harm or low level harm incidents and the increase showed assurance of a good reporting culture. No significant concerns highlighted for division apart from Critical Care directorate where she is working with the teams to try and improve reporting from the area. **Jan 19 - Div 1 nothing further to add. Incidents reviewed as part of monthly Divisional Governance meeting. Feedback being actively sort from areas in regards to ePMA roll out to ensure no increased risk.**	**Dec 18 (Alison.T) - New datix categories have been implemented. Monthly IGR reports sent to directorates contain details on number and categories of medication incidents. Further detail provided by governance officer and directorate pharmacist where there is one.**	
1.4.2	Medication prescription, administration and storage (including chemotherapy drugs)	Dir Phar	31/12/2018	MMG	Audits				Review medicines storage security (including high risk medicines) in Outpatients core service Dv 3 - Pharmacy: Framework in place. Reporting being escalated to senior nurses, matrons and through pharmacy governance. **Dec 18 Alison.T - Framework in place. Reporting being escalated to senior nurses, matrons and through pharmacy governance.**	**Fiona McKean - Jan '19 update There is a rolling programme of audit in place across all ward and departments. Any deviations from practice are raised with the ward manager and a reaudit planned.**	Implement and report Medication audit programme (prescription, administration and storage)	Dir of Pharm
1.5	Ensure secure access for medicines and temperature monitoring. (Medicine and Surgery)	DMT	28/02/2019	MMG	Audits				Follow up to ensure fridge temperature checks in ED. Dv 3 - Pharmacy: Fridge monitoring SOP progressing. On agenda for November Policy Group (Alison.T) Fridge monitoring SOP progressing. On agenda for November Policy Group. **Fiona.McKeon - Jan '19 update - to go to February Policy Group following suggestions made at November's meeting**	Dv 1 - No issues reported to Division in regards to Fridge temps -managed locally at present. Jan 19 - nothing further to add.	Review arrangements for the oversight of fridge temperature checks and reporting to areas.	Dir of Pharm
1.6	Explore staffing issues in midwifery through Birth rate+ review and identify links to SIs.HoM	HoM	30/11/2018	DirGovM	Business case				Monitored via maternity dashboard			
1.7	**Number and Learning from Never Events**											
1.7.1	AfPP Review	DivMT	31/01/2019	QSIG	Report	Dv 1 - No never events.	Dv 1 - DMT team members	Mar-19	Dv 1 - To ensure all team members attend AfPP training.	Divisional oversight of compliance results and monitoring of progress. Dv 1 - Peer review completed and local action plan in place; being monitored via Matron 1:1 with Head of Nursing currently. First all team training event took place on 10/10/18 with 56 attendees. Further training due 18/10/18 with 58 staff expected to be in attendance. Further dates to be agreed - probably for January 2019. **Jan 19 - Div 1 circa 240 staff now trained with AfPP - awaiting formal feedback and a review of staff attendance. Business case underdevelopment for an increase in educational staff to Critical Care that can provide Human factors training and offer immediate support and live debriefs following incidents. Reviewing the potential for a new project in relation to 10,000feet.**		
1.7.2	NatSSIPs/LocSSIPs in practice	DivMT	31/12/2018	QSIG	Audits	Dv 1 - Full suite of LoCCSIPs per directorate with annual plan for audit and compliance.	Ian Badger - Dv 1 - Ian Badger for division 1	Mar-19	Dv 1 - Each directorate will have a suite of LocSSIPS available within their intranet page. Annual audits will be performed on these LocSSIPs and presented to Div. Governance and then QSIG.	Audit of NatSsips and LocSsips via QSIG. Divisional oversight of compliance results and monitoring of progress. Dv 1 - Peer review completed and local action plan in place; being monitored via Matron 1:1 with Head of Nursing currently. First all team training event took place on 10/10/18 with 56 Dv 1 - Audits reviewed by Directorate at each Divisional meeting prior to presentation at QSIG. Directorates challenged on any concerns from results and reattendance offered as necessary. Dv 2 - each Directorate has an established set. Discussed at Divisional performance meetings.Dv 3 - DMT: need to scope LocSSIPs in diagnostic and outpatient services to identify any gaps and resolve. **Jan 19 - Div 1 no further update.**		

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1.7.3	Review WHO checklist use in theatres and interventional procedures including ongoing educational support.	DivMT	30/08/2018	QSIG	Audits	Dv 1 - Qualitative audit results show full compliance to checklist and brief.	E. Lengyel, Matron & M. Ahudja, CD. DMT	Mar-19	Investigate and address WHO non-compliance issues across relevant Directorates (notably theatres NX, CCH.	Divisional oversight of compliance results and monitoring of progress. Dv 1 - Quarterly results discussed at Divisional Governance in October - main issue is in regards to the sign in not being done separately - it has been agreed that the WHO documentation should now be reviewed and amended to provide a further focus. A working group is being set up by Matron to lead on this. Further discussion on completion n of draft document to go to Div. Gov meeting. Dv 3 - DMT: WHO checklist returns gathered monthly and reported quarterly to SIG by Divisional Heads of Nursing. **Jan 19 - Div 1 no further update**	Undertake safety culture survey.	Nursing and Quality, HR
1.8	Identify causes of poor documentation including HF and redress (including fluid and nutritional records, re-positioning, patient care and treatment, care planning records) .	DMT	31/05/2018	DivGovM	Audits		Audit/monitor documentation compliance in ED, Medical core service Dv 2 - Monthly audit undertaken, reported the divisional governance.		Undertake care pathway review (including ED system and processes) to understand challenges/barriers. Outline expected standards via SOPs, training, induction and appraisal. Identify and undertake local prospective audits of records with prompt/live reporting of results.	Performance oversight monitoring of Documentation audit compliance. Monitor action plans from external reports, HF reviews and action plans in ED. Dv 1 - Documentation audit discussed at Governance in October - main issue is in regards to stamps. Communication has been sent to each directorate for how to order stamps and to share audit results locally. Poor compliance with documentation evident through Health assure dashboard which Head of Nursing discusses as necessary with relevant areas. **Jan 19 - Div 1 main issue continues to be stamps.**	Develop system to enable live audit reporting. Establish resource requirement for HF training/expertise at RWT. Nursing audit review. Local audit plans to consider local themes/compliance gaps.	HGLS/QSIG
1.9	Establish system and address triage delays in ED.	DMT	31/05/2018	DGovM	SOP				** Progress update required**			
1.10	Mental Capacity Act documentation and compliance.	HoSG	31/01/2019	SSG	Audits		Fiona Pickford		Medical and Maternity core service to address MCA/DoLs training compliance. Review and assure on staff training and competence in Surgery.	Training Needs Analysis (TNA) was completed to identify specific staff groups who needed to complete the training. 7. MCA and DoLs training is incorporated in the level 2 safeguarding adult and children's eLearning package which is available on kite site. Five additional training sessions have been provided in September 2017 by an outside speaker Susan Lassetter- MCA/DoLs Project Worker. MCA and DoLs training compliance is now at 97.7% (Sept 2018) MCA/DoLs was promoted on the Safeguarding Awareness week on 2nd October 2018. 12. Staff from the safeguarding team to be out on the key wards daily asking if there are any patients in tag bays in particular that would warrant DoLs. A meeting as taken place with Sister and the Dementia Nurse Consultant on C22 on ways the staff can complete the DoLS applications when working in the bays. There has been an increase in the number of urgent DoLs applications received from C22.15. MCA and DoLs audit to be completed by November 2018. The staff group includes all clinical front facing staff so would need to complete level 2 safeguarding adults and children's e-learning package available on kite.	**Jan 19 F Pickford - Develop programme of routine audit of safeguarding documentation (prioritising high use areas) (Fiona Pickford - Jan update) MCA/Audit in progress across ward areas which commenced October 2018. Awaiting findings and report January 2019.The third MCA and DoIs audit has been completed in 16 clinical areas. This shows a continued poor working knowledge from staff around DoIs, Particularly in relation to whether a person has to have a mental disorder in order to apply for a DoIS and in relation to who can assess mental capacity.** **Actions taken:** **• Fact sheet regarding what is a mental disorder and other aspects of MCA and DoIs developed and disseminated to ward areas.** **• Continued bespoke training 1 to 1 on ward and clinical areas by Safeguarding staff.** **• Weekly staff attendance at West Park and Cannock by named nurses to provide support and advice in clinical areas.** **• Continued weekly reporting of DoIs activity to Chief Nurse.** **• Continued bi weekly check and challenge with local authority regarding status of outstanding DoIs requests.** **• MCA and DoIs continues to be monitored through the creating best practice work stream.** **• Planned attendance at Senior Nurse forum in February 2019 to keep issues in focus.**	Head of Safeguarding/ Safeguarding Steering group
1.13	Establish system in theatres to ensure theatres are fit for purpose when in use (NX and CCH theatres).	DMT	31/05/2018	DivGovMeeting / Environmental Group	Audit		Tom Butler - Lewis Grant, DCOO	Mar-19		Div, Gov & Estates Dv 1 - Building work complete. Fire compartmentalisation starts wc 22/10/18. CCH work complete. Cleaning logs have been amended to address all equipment in each area. Band 7s continue to report monthly to Matron and escalate as necessary to estates. Theatre trollies are damp dusted daily. Also have appointed an environmental support worker whose job is to clean and maintain a tidy area/high standards I Theatre including equipment reports. No audits failed this quarter.- Theatre action plan to be developed **Jan 19 Div 1 - Theatre 5 Beynon, cracks in floor being amended wc 7/1/19. Fire compartmentalisation work continues. No environmental audits have failed.**		
1.14	**Agree Trust Quality/Safety Cultural Survey**	CNO	31/08/2018	Board	Survey				**(Adam Race - Jan '19 update) This looks like it's a cultural survey that Nursing and Maria Arthur have been working with Daniela on, but given the potential cross over with Staff FFT, Pulse Surveys and the Staff Survey this has not progressed. Daniela is meeting with Jake Botfield and Maria Arthur next week to discuss approach and I have suggested looking at the Kings College London Cultural Barometer if we're to do something nursing and ward specific.**		**Trust to identify and undertake a Culture survey with financial year 2018/19. NSF - Nursing (Adam Race - Jan '19 update) In terms of update from a corporate perspective we are developing Pulse Surveys with a view to developing the survey questions over Q4 to test the temperature around morale etc. We have just concluded the 2018 staff survey and are reviewing results – full benchmark results for the Division are expected in Feb.**	Nursing and Quality, HR

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1.14.1	Completion of survey annually by departments	DMT/Heads Dept	31/12/2018	Workforce	Survey reports		Alan Duffell		**(Adam Race - Jan '19 update) All Directorates/sub-teams to undertake annual stress risk assessments. All departments to communicate chatback results, review and complete action plans following feedback.** The action here appears to be to do the survey that's developed as part of 14.1 unless I'm missing something. An update on the Staff Survey Actions went to the October 2018 WODC and the new survey closed. As above, we'll be cutting the data by division as the benchmark results land, but are looking at the preliminary results now so that we are ahead of the game.	Ensure oversight of Chatback results and action planning. Dv 1 - culture survey for Maternity completed. Dv 3 - DMT: stress risk assessments monitored as part of H&S assessment requirements. Key findings from stress RA, Chatback, Staff Survey etc. reviewed at monthly performance meetings.	Monitor and follow up response and action planning in hotspot areas, offering further support as needed.	HR
1.15	Develop the model of Discharge Lounge including vision and DMO	DMT	31/03/2019	DivMT	Model					Review staff training/awareness of Discharge lounge staff re clinical care/deterioration/escalation - Dv 2 - SOP completed, approved by Division. Allocated funding to commence some building re-configuration. This will incorporate quality initiatives for improved patient experience. the programme of works will commence on 3rd March 2019		
1.16.2	Ensure a Safeguarding system for full staff compliance to Policy	DMT/Heads	31/08/2018	DivGov	Training records	Dv 1 - Training to be consistently green across division.	Dv 1 - DMDs, Head of Nursing, Head of Midwifery	Dec-18	Management to review, cleanse and follow up red mandatory training. Address safeguarding training non compliance in Maternity , Diagnostic Imaging particularly Medical staff L3) -	Division to set a 2 month improvement target for red mandatory training. Dv 1 - Safeguarding Adults: green at 97.9%. Safeguarding children level 1: green at 98.7%. Dv 2 - Current process has not seen improvement particularly regarding medical staff compliance. New targeted communication process to be piloted as of October 2018. Dv 3 - DMT: Mandatory Training a focus of monthly performance meetings Dv 3 - Directorates: Action plans in place. Discussed weekly at Team meetings and staff briefings. Formally to reported to Division to monthly. **Jan 19 Division 1 - Division red for all safeguarding mandatory training - emphasis to be placed on getting staff trained over the next quarter.**	Review target populations for safeguarding training levels (within policy) to ensure appropriate and achievable. Safeguarding team to target low compliance areas and staff groups for targeted training.	Head of Safeguarding
1.16.3	Implement MCA/DoLs assessment audits	DMT	31/01/2019	DivGov/SSG	Audits				**(Fiona Pickford - Jan '19 update) Dv 2 - all nursing audit under review. Division - Dv 1 - Not complete Trust: Safeguarding team to devise routine audit for MCA/DoLs and reporting results .**	Dv 1 - Not complete Dv 2 - all nursing audit under review. all Nursing metrics are being reviewed at an away day on 7th December Dv 3 - Implement MCA/DOLs assessment audits- Nursing audits are being reviewed across the division. 3m review **Jan 19 Div 1 - nothing further to add.**	Safeguarding team to devise routine audit for MCA/DoLs and reporting results . (Fiona Pickford - MCA/Audit in progress across ward areas which commenced October 2018. Awaiting findings and report January 2019. Audit findings reported to Chief Nurse and action plan in place.	Head of Safeguarding
2.0 Effective												
2.1	Audit Sepsis 6 compliance and identify issues to action including human factors	Sepsis leadsx2	31/01/2019	DPG	Audits		Yat Wah Li		This is an ongoing action with audit in the form of data submission for CQUIN in addition to sepsis reports provided as part of the DPG meeting on a monthly basis. we have focused on ED, haematology/oncology and recently paediatric wards with regards to sepsis management. We will also be interviewing for sepsis nurses on 27th November and have VitalPAC (with NEWS2/sepsis module implementation) being delayed until 31 Jan 2019.	CQUIN Audits 1/4 yearly ED and Inpts	Develop routine annual audit plan for Sepsis, monitored by DPG. CQUIN compliance IQPR VitalPac upgrade and CD rollout sepsis nurses	DPG
2.2	Develop structure/process for Mortality reviews	Medical Director	30/08/2019	MRG/TB	Report		Ananth Viswanath		Directorate management to monitor the completion and analysis of death reviews for the service ensuring adequate trained reviewers and time to complete. Death review analysis/outcomes to be actioned at local Governance/Mortality meetings. Dv 3 - Paediatrics: Mortality reviewed as part of Directorate performance and local governance processes (Ananth.V) - learning from deaths policy (OP 87) will be revised to incorporate Medical Examiners model that dovetails with mortality reviews by Dec '18 - Medical Examiners appointed and will be accommodated in a purpose-built bereavement centre by Nov '18 - Medical Examiners will undertake initial scrutiny of all deaths in hospital and identify cases for more detailed SJR reviews by Dec '18 - We are aiming to have a team of dedicated and trained mortality reviewers to ensure the reviews are timely and independent by Jan '19. - An IT platform to support the learning from deaths agenda and reduce administrative burden is being commissioned by Aug '19	Divisions to oversee Directorate Mortality review (performance and outcomes) as routine within their Quality/Governance agenda. v 1 - Discussed as a standard agenda item quarterly at Divisional Governance. Head of Nursing encouraging more staff to attend SJR training. Mortality returns are overseen by Division and areas invited to explain poor compliance to div gov meeting as necessary (most recent being Crit Care). Dv 3 - DMT: Mortality a standing item on Div Gov agenda. **Jan 19 Div 1 - as previous statement - work continues.**	Increase pool of staff trained in SJR. Project group to address key issues including backlog of reviews, standard mortality reporting, policy compliance etc. Trust Mortality group to monitor assurance on mortality review outcomes. ME Role commences 3/12/18. Q! Mortality plan	Mortality Project Group
												Green Gwen Nuttall
2.4	National benchmark of mothers receiving steroids post prem delivery – outlier result in Maternity	Dir MT	30/11/2018						Maternity to investigate and address result to National benchmark.	Dv 1 Policy in place for steroid use for preterm mothers is in line with national best practice / guidance.		
2.5	Treatment waiting times disaggregation by site to address specific issues – Surgery	DMT Surgery	30/11/2018							Amend waiting time reporting by site.**Jan 19 Dv 1 - Suggest to close. Same on both sites. Work already part of on-going programme through OTEG.**		
3.0 Caring												
3.1	Identify ways to reduce lengthy delays for patient transport.	Div 2 DCOO	30/04/2018	DivMT	Audit				Review/establish contract compliance monitoring.Patient transport issues are being worked through by Division 1 as this department belongs to that Division.		Esculated to CCG contract monitoring in place. Improving position. Test of change will be winter	
4.0 Responsive												

Domain	Action	Accountable lead	Timescale	Assurance group	Evidence	Stretch action	Accountable lead	Timescale	Action relating to Directorate/Division/Trust			Trust Lead/Assurance group
									Directorate	Division	Trust	
4.1	Achieve national targets for RTT - external review	DCOOs	30/06/2019	Contract & Performance / DivMT	Report		Kevin Stringer / Gwen Nuttall / Mike Sharon		Dv 3 - DMT: RTT monitoring in place . We did however have an intensive support review (external) for our cancer 62 pathways. This report was completed in Aug 18, the evidence via report is available and has been shared with Finance & Performance, Quality Governance and TMC. The accountable leads are myself and Simon Grummet (Trust cancer lead).	Review surgical admission pathways to improve RTT Dv 1 - Trust wide issue which is ongoing and picked up in other forums. Highlighted in cover report	RTT performance monitored.Improvement plan in place	
4.1.1	Implement recommendations	DCOOs	tbc	F&PC	IQPR							
4.1.2	EPAU having no weekend service – Gynae	Dir MT	30/04/2018						Gynaecology to review weekend service provision for EPAU	Dv 1 - EPAU – no service at the weekends this relates to challenges within the sonography service. HOM and Matron are future proofing service for Nurse and Midwife led sonography service – 2 RM's and 2 RN's are undergoing training and this will be a rolling training programme for the future .Presently the sonography service is challenged – vacancy and sickness has created some capacity issues, this is a risk that is escalated to divisional RR, and COO is aware. This means that presently we are unable to provide a 7 day service, this is under continual review and is being monitored closely. Recruitment is in progress – there is a recognised lack of experienced sonographers locally and nationally. Succession planning and development of staff in scanning competencies to support service is in progress.		
4.1.4	LD/Dementia provision – Diagnostic	Radiology Dir MT	31/03/2019						Directorate to review LD patient needs within the service and address Dv 3 - Radiology: There is no written process for this as yet. Work with Dementia Leads to support best practice hoping to have implemented by March 2019 LD/Dementia Provision Diagnostic- Working with Dementia leads for completion **Jan 19 - Fiona.P - LD All Ages Strategy completed. New LD posts (children and adult) x 2 Band 6 in recruitment stage. Expect to be in post by end of March 2019.**		Strategies rollout flags on portal (Fiona Pickford) LD All Ages Strategy completed. New LD posts (children and adult) x 2 Band 6 in recruitment stage. Expect to be in post by end of March 2019 (Fiona Pickford - Jan '19 update) Outreach team recruitment completed and 2 band 6 Learning Disability Nurses appointed and expected in post March 2019. Awaiting decision from CCG around additional funding for band 4 support posts. Outreach team work-plan to meet LD strategy to be developed by the end of February 2019.	
5.1	Develop new Mandatory training model	Dir.Workforce	01/04/2019	Education and Training / TMC	Kite site		Louise Nickell		This review is currently underway, and a Director confirm and challenge step will now be part of the sign off around MT topics/frequency and target groups. Each topic has been allocated a 'reader' of the learning content, who has worked with the SME to provide first level challenge and scrutiny around course content, learning outcomes and user acceptability- this has now been completed for all topics. Next stage is to redesign the learning content into new e learning packages, and test for user acceptability and accuracy. Then the director level scrutiny panel will occur between now and March. (Zoe Marsh - Jan '19 update) • All core skills mandatory packages have now been reviewed and content redesigned and aligned to learning outcomes (length In most cases significantly reduced) or moved to e-learning for Health Content (IG. E&D, Safeguarding, CRT). Where packages have been redesigned these are currently being produced by Medical Illustration and will be ready within the next few weeks. • The team are working on an options appraisal paper in relation to agreeing mandatory training topics are categories for 2019/20. The options appraisal paper will be ready this month and could either be discussed at a confirm and challenge meeting or Directors.		**Jan 19 - Review mandatory training policy and training subjects with particular focus on target groups, compliance targets/thresholds, frequency and mode of training.. (Louise.N) Dec 18- Confirm and challenge meetings underway for all MT topics with SME and educationalists reviewing content of training material etc. Next step is exec level challenge- Jan and Feb 2019. All revised packages to be in place for April 2019. In addition knowledge assessment options now available for e learning packages for those who are confident in their own knowledge of the topic and can move forward to the question deck.**	Head of E&T and SME
5.2	Confirm Sepsis training requirements for Maternity staff	Head of Midwifery	30/01/2019	Directorate Gov. Group	Minutes				X	**Jan 19 - Each topic has been allocated a 'reader' of the learning content, who has worked with the SME to provide first level challenge and scrutiny around course content, learning outcomes and user acceptability- this has now been completed for all topics. (Emma McCartney) Sepsis is covered on our Intrapartum Study Day and has been since the beginning of 2016. It is still being covered on a monthly basis throughout 2018 and will continue.Continues into 2019, compliance will be in line with national 90% target**	As in line with Trust	
										Then the director level scrutiny panel will occur between now and march		
5.4	Effective management of risk registers to include timely Closure of actions and risks, relevance of evidence.	and Corporate Heads	30/11/2018	QSIG/QGAC/Audit Committee	Div Data pack/TRR BAF/Internal Audit report		Shashidhar Cherukuri		All risks must but reviewed and updated monthly. A monthly risk register review meeting is held to oversee and follow up the TRR updates.	Divisions to devise arrangements to oversee the management and progression of Directorate risk registers. Dv 1 - Divisional risk register reviewed monthly at div gov meeting. Directorate risks reviewed as part of Quality meetings. IP risks also reviewed at Divisional nurse leadership meeting. Dv 3 - DMT: As per policy risks <12 reviewed min. quarterly; risks 12+ reviewed monthly. Reviews take place at both Directorate and Divisional level. **Jan 19 - Div 1 - nothing further to add.**	Review central governance and resource and structure to oversee risk register management.	Head of Governance and Legal Services

Domain	Action	Accountable lead	Timescale	Assurance group	Evidence	Stretch action	Accountable lead	Timescale	Action relating to Directorate/Division/Trust			Trust Lead/Assurance group
									Directorate	Division	Trust	
5.5	Review RCA process for patient and staff involvement and feed learning into training programmes and system learning and link with SJR process.	Head of Governance	31/03/2018	MRG / QSIG	Policy			Dec-18	Staff implementing the Trust DoC process are required to invite input of patients/relatives to inform the RCA investigation. The Duty of Candour (DoC) process is applied to all serious incident investigations. Following review in 2018 the DoC process includes the requirement for clinical leads delivering DoC to invite the patient/family to state any areas of concern they wish to highlight/form part of the investigation. This offer is also stated in DoC documentation to the patient. Areas identified are passed to the investigator to form part of investigation or address via other appropriate processes eg PALs, Complaints etc. The existing link between SJR and SUI process will ensure that where a death is reviewed and triggers a SUI or investigation the process (including DoC) will apply as above. The new ME role and bereavement team will also have a role in the support/involvement of patients/families		Current RCA training to have independent review by HF expert and inform further development. Review central governance structure and resource for RCA oversight and theme analysis to inform learning and improvement. Develop improvement assessment/evaluation framework. SJR process revised - learning log	Head of Governance and Legal Services
5.6	Establish Teletracking assurance around patient information governance.	Head of Comms/DPO	31/05/2018	IGSG	MOU		Raz Edwards		**Raz Edwards - Jan 19 update- Asset owner for teletracking to be established who will lead on doing a PIA and reviewing use.**		Need further work	IGSG
5.6.1	Patient/public poster re use and management of information	Head of Comms	31/01/2019	IGSG	Posters		Sally Evans				Need further work	
5.6.2	Publish on line fair processing notice.	DPO		IGSG	Website		Sam Smith		**Raz Edwards- Jan 19 update - Trust Wide privacy notive has been publiched on thust Internet and service level notices are being developed.**		Need further work	GDPR Group
5.6.3	Undertake Privacy Impact Assessment.	Head of Governance & Head of Comms	30/08/2018		PIA							
5.7	Review internet/intranet management processes	Heads of Comms/Med Ill	30/04/2018	tbc			Sally Evans / Nigel Beardsmore				Intranet under review, new intranet launch planned April '19. Internet is having an ongoing review.GDPR - training, policy review in progress	
5.8	Minimise risk of IG breaches through open log ins	DMTs	23/04/2018	IGSG	Audit	Dv 1 - No ICO reportable incidents.	Dv 1 - DMT	Mar-19	Implement local IG audits and compliance follow up.	Dv 1 - IG breaches to be monitored via div gov and RCA investigations and action plans. Dv 1 - Divisional IG breaches - in the first 2 quarters there have been 135 incidents reported trust wide with 37 related to division 1. Compared to the same time last year there has been a decrease of 31 incidents. This is the second consecutive year where division have seen a significant reduction in total number of incidents reported. Trends relate to data quality issues or data being disclosed in error with only 1 occurrence of unauthorised access. Cardiac has tripled their amount of incidents from 3 to 9, division have requested an aggregated RCA in respect of this. Dv 3 - DMT: directorates engage with IG audits undertaken via IG team. **Jan 19 - no further comments.**	Review and publish local procedure guidance for IT login security. Implement Trust IG audits once IG resource agreed.	IGSG
5.9	Review of patient notes' storage and security in each ward/department	DMTs	31/04/2018	Med Records' Group	Audit		Sam Smith (1) Head of Health Records	Dec-18	**Sam.Smith Jan 19 - In process of confirming with all Matrons that they have got lockable cabinets on the wards. 27.11.18 email sent to all matrons to confirm areas all have secure lockable areas for records.**	Dv 1 - Head of Nursing to review all areas via Matrons for storage of patient notes and ensure correct equipment ordered as necessary. Dv 1 - Checked earlier in the year and trolleys ordered. To recheck in October to ensure all now in place. Dv 3 - Directorates: Management of patient notes in line with Trust policy. **Jan 19 Div 1 - action not completed. Results to be delivered by end of January 19.**	IG audit programme to prioritise Medical, Surgery, Diagnostics core Service.	IGSG
5.10	Each department to complete Stress survey annually	DMT/Heads	31/01/2019	WODC	Reports		Alan Duffell		**Priyanka Nar update Jan '19 - Team Stress RA and action plans to be developed and reviewed in Directorates with minutes of ongoing monitoring. Occupational Health's stress risk assessment is next due for review on 07/09/2019. The team have recently completed their stress risk assessments. Feedback is given internally within our departmental monthly meetings and at the directorate governance meetings.**	Division to oversee the redress of risks falling from Stress RA and action plans. Dv 1 - Stress risk assessments usually managed at directorate level; Head of Nursing has now requested to see local stress risk assessments for the top 3 areas in division with the highest turnover rates/lowest retention levels. Dv 3 - DMT: review key findings from stress RAs via performance meetings. **Jan 19 Div 1 - no further comment.**	Trust H&S annual audit programme to oversee compliance with stress RA/action planning and risk redress. Reporting to H&S Steering group and to COG. **Jan 19 - H&S Team are currently collating a report of the outcomes of the department risk assessments to identify the stressors and actions/controls being undertaken, this will be presented to the HSSG in March then shared with Divisions and reported through Compliance Oversight group.**	HSSG
					Aspirations							
5.11						Each department to develop a "Good to Great" CQI plan	DMT/Heads	17/08/2018	QSIG	Plans Dv 1 - Directorates currently addressing. Dv 3 - Directorates/DMT: Monthly CQC self assessments undertaken and discussed at monthly performance meetings. This includes actions to progress from good to great. **Jan 19 Div 1 - Quality meetings booked in where directorates are expected to bring their local action plans with stretch targets for further scrutiny.**	Dv 1 - Division to discuss at each quality meeting and review quarterly.	
5.12	Develop a management handbook - aide memoire	DCEO	31/08/2018	TMC	Handbook		Senior Nurses / Education					
5.13						Develop a Trust overarching CQI strategy and plan	Mike Sharon	31/08/2018	TMC	**Strategy /plan (Simon Evans - Jan '19 update) New structure proposal and business case approved at TMC. Full CQI team appointed to. Currently looking to recxruit to a clinical lead to support the programme.**		

Domain	Action	Accountable lead	Timescale	Assurance group	Evidence	Stretch action	Accountable lead	Timescale	Action relating to Directorate/Division/Trust			Trust Lead/Assurance group
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5.14			31/12/2018			Develop an enhanced model of RCA	HoG	30/08/2018	Each Directorate to ensure adequate staff training RCA investigations.	Divisional oversight and RCA signoff to include further guidance and scrutiny on the use of 5 why's to establish root causes and closer consideration of human factors affecting the occurrence.	Internal RCA training package to be reviewed to consider human factors input. Training and guidance to be extended to investigators and to others involved in the RCA review and approval process. Central Governance structure changes to include roles to support RCA investigations/investigators and to provide closer oversight of final RCA reports. Human Factors/RCA training programme commenced October, with 2 further days scheduled for Nov and Dec. Investigations Officer role has been submitted on Trac for advert	Head of Governance and Legal Services
5.15	Q1 methodology - corporate approach, resource, tools, support Query - presume this means QI methodology (Quality Improvement)		30/04/2019				Mike Sharon		Consultation and Implementation	Consultation and Implementation	Trust to develop and implement a Quality Improvement strategy. Consider other requirements i.e. Project group for roll out, QI expertise and training, potential resource etc. Q1 plan	Nursing and Quality
5.16	Review of audit programme - QIPP to engage medical staff						Audit				Trust Audit plan includes QIPP projects. Medics offered and encouraged to select from plan or additional items relevant	Trust Audit Convenor
5.17	Monthly round up - key note speakers						Sally Evans - Head of Comms					
5.18	Celebration of success		30/11/2018				Sally Evans - Head of Comms			Dv 3 - DMT: Division 3 newsletter "Showboat" to share items of interest, good news, successes, monthly "Above and Beyond" award	The Trust now has in place, Well Done Wednesday - social media. Trust Brief - all user bulletin, Trust Talk 1/4 newsletter, Nursing Newsletter, monthly, Div 3 "showboat	
5.19	Local Policy out of date (Chaperone and others unspecified) No local policy for handling patients of no fixed abode, migrant community) – Diagnostic	Dir MT	TBC	Policy Group / Div MT					Directorate management to review local policies. Dv 3 - Radiology: Policies now in date and under regular review.			

Appendix 1

CQC Action Plan

Beige writing Maria Arthur
Red writing Clair Hobbs
Blue writing Tracy Palmer
Purple writing Nicky Ballard
Green Sandra Roberts

Domain	Action	Accountable lead	Timescale	Assurance group	Evidence	Stretch action	Accountable lead	Timescale	Action relating to Directorate/Division/Trust			
									Directorate	Division	Trust	Trust Lead/Assurance group
1.1.4	Mixed equipment storage clean in dirty – Diagnostic	Radiology Dir MT	30/11/2018			Environmental Audits			Review and address clean/dirty storage and include within local environmental audits. Dv 3 - Radiology: The clean and dirty storage has been reviewed and is now separated out.Mixed equipment storage clean in dirty- Diagnostics			
1.1.6	Establish stock expiry checks – Diagnostic	Radiology Dir MT	30/11/2018						Directorates to ensure robust checking systems for stock expiry. Dv 3 - Radiology: Checking systems in place.Establish stock expiry checks Diagnostics- weekly review Audit to confirm it is working.			
1.11	Develop SOP for local checking of Oxygen cylinders to comply with national regulation.	DMTs	18/04/2018	Med. Gases Group	Audits		Sandra Roberts / Brendan Houston		Implement O2 check in local processes according to Policy (notably in Diagnostics).Dv 3 - Radiology: SOP in development - Introduced as a SOP and put in to OP86 policy and ratified in April '18	Dv 1 - Areas checked as part of quality rounds and no incidents have been reported in regards to Oxygen cylinders	Review policy requirement for O2 checks and roll out with compliance oversight by the Medical gases group.	Medical Gasses group
1.12	Review Dress Code policy and clarify wearing of scrubs, and establish process for observing non compliance	Dir WOD	30/11/2018	Policy Group	Policy				Directorate management to communicate, enforce and monitor compliance with Dress code policy (notably CCH theatres).	Trust policy reviewed and amended 4th Oct '18		
1.16.1	**Review Safeguarding training policy for scope**	HoS	31/10/2018	SSG	Policy				(Fiona.P) Revised Safeguarding Children and Adult Training Programme commenced which covers October 2018 to 2021.		Review	
2.3	Implement a review of elective surgical readmission rates	DMD Div1	30/11/2018	DivGov	Audits					Dv 1 - Suggest to close. Admissions categorised into related and unrelated conditions. Results so far show we are below national average.		
4.1.3	No ISAS sign up/accreditation – Diagnostic	Dir MT	30/11/2018						Radiology to review/consider accreditation requirement. Dv 3 - Radiology: This is not being considered at present TMC to note and approve			
4.1.5	No urgent referrals process – Diagnostic	Radiology Dir MT	30/11/2018						Document and communicate a process for urgent referrals. Dv 3 - Radiology: There is no written process for this - urgent request on the electronic requesting system in place			
4.1.6	Facility for patient isolation – Diagnostic	Radiology Dir MT	30/11/2018						Directorate to review the service facility and address Dv 3 - Radiology: SOP 27 is the written procedure for patients who require isolation			
4.1.7	Interpreter facility for patients - Diagnostic	Radiology Dir MT	30/11/2018						Directorate to review the service facility and address Dv 3 - Radiology: Interpreters are booked in line with the Trust Interpreting Policy			
5.3	System of assuring compliance to PAT test policy	Head Med. Equipment	30/11/2018	Med. Devices Group	Audit data		Rob Millard		Ensure all equipment checks are within date - ED, Medical core service.		Review arrangements for PAT testing and assurance reporting.	Head of Estates

Appendix 2 Primary Care CQC Action Plan					Monitoring Plan (Monitored by Directorate Management Group).	Operational Leads.
1. CQC Recommendation	**Compliance**	**Lead**	**Completed Date**	**Action**	**Monitoring Plan (by DMT)**	**Guidance Lead**
Increase Cervical Cytology for Thornley Street Medical Practice.	Yes	Katie Welborn - Senior Matron for Primary Care and Sexual Health Sevices.	01/03/2020	1) Aduit. 2) Recruitment. 3) Workforce Development .4)Weekly Performance Metrix.	Presentation of regular audit data to Directorate Governance Meeting.	Katie Welborn - Senior Matron
Actions:	**Compliance**	**Comments**	**Predicted Completed**	**Resouce Required**	**Monitoring Plan (by DMT)**	**Guidance Lead**
Audit to undertaken to establish the reason for low uptake rate of Cervical Cytology Rate.	Completed	Baseline audit undertaken and presented to Governance Directorate Meeting.	01/02/2019	None.	Audit Presented at Directorate Governance Meeting.	Katie Welborn - Senior Matron
Recruitment:	Yes	Recruited to 1 x 0.8 Band 6 wte Nusre to deliver additional sessions to Thornley Street Practice. Approval gained to recruit for an additional 1x 0.8 Band 6 Nurse and 1.0 wte Band 3 Admin support. Vaccancy on Trac	01/02/2019	None. (Funding provided by commissioning).	Update presented to the DMT Performance and Governance meetings.	Katie Welborn - Senior Matron
Workforce Development	Completed	Training needs analysis and practice profile mapping exercise undertaken, to ensure the right skill mix to meet population demand.	Feb-19	Money for Cervical Cytology Training. KW - has discussed with LC at the CCG.	Presented to DMT operational Group and Head of Nursing.	Katie Welborn -Senior Matron.

Weekly Performance Metrix to be presented to KW.	Yes	Band 6 SN to collect weekly data on the uptake of Cervical Cytology testing.	01/02/2019	Require admin support to collect data.	Presentation of regular audit data and data collection to DMT.	Katie Welborn - Senior Matron. Kelly Dukes, Julia Freeman.
Primary care providers should ensure that robust safety netting arrangements are in place for those patients who have not attended Cervical Cytology Screening.	Yes	Working with primary care leads to facilitate these safetynetting arrangements . CH to consider using MJOG/Docman to recall patients.	Mar-19	Standardised referral methood and proforma has been developed. Ongoing educational activities to promote	Regular audit and presentation of data at the DMT	Charlotte Hill - DDM
2) CQC Recommendation	**Compliance**	**Comments**	**Completed Date**	**Action**	**Monitoring Plan (by DMT)**	**Guidance Lead**
Standardise emergency medication in Primary Care.		Standard Opertional Policy required for Primary Care. Lead Pharmacist role and responsibilities to be agreed.	1st April 19	DMT - to identify Lead Pharmacist for Primary Care.	Standard Opertional Policy required for Primary Care. Lead Pharmacist role and responsibilities to be agreed.	Julian Parkes - CD, Charlotte Hill - DDM, Katie Welborn -SM, Lead Pharmacist -TBC.
Actions:	**Compliance**	**Comments**	**Completed Date**	**Resouce Required**	Monitoring Plan (by DMT)	**Guidance Lead**
Establish Pharmacist capacity in Primary Care.	Yes	Work with Pharmacy Department to review service specification and capture current capacity and demand.	1st Feb 19	Pharmacists Resource	Service Review presented to Directorate Performance Meeting.	Charlotte Hill - DDM
Identify a pharmacist Lead for Primary Care, to review current national standards and develop Standard Operation Policy for Emergency Medication in Primary Care.	Yes	Healthcare anaysis of pharmacists currently in progress by CH. Support required from RWT Lead Pharmacist and CCG Lead Pharmacist.	1st March 19	Pharmacists required to review current processes and standardise within Primary Care.	CH to present service review/healthcare analysis report to the DMT. Lead Pharmacist to be identified and to review, amend and present SOP to the Directorate governance Meeting.	Julian Parkes - CD. Charlotte Hill - DDM

Lead Pharmacist to implement SOP across VI and nominate a pharmacist from each practice to audit Processes.	Yes	Safety Checklist to be revised to include daily auditing/checking of medications in Primary Care.	1st April 19	Lead Pharmacist	Implementation report to be presented at Directorate Governance Meeting.	Lead Pharmacist.
3) CQC Recommendation	**Compliance**	**Comments**	**Completed Date**	**Action**	**Monitoring Plan by DMT.**	**Guidance Lead**
Audit Prescribing for Non-Medical Prescribers working in Primary Care.	Partially Compliant	Skills analysis undertaken for nursing workforce.	1st April 19	Skills analysis required for pharmacists. Lead pharmacist to be identified and have responsibility for auditing NMP pharmacists.	DMT	Katie Welborn - SM
Actions:	**Compliance**	**Comments**	**Completed Date**	**Resources Required.**	**Monitoring Plan (by DMT)**	**Guidance Lead**
Develop a database of NMP/V300 in Primary Care.		Skills analysis has been undertaken. Database to be devised.	28th Feb 19.	Admin Support Required		Katie Welborn - SM
Lead Practice Pharmacist to produce a monthly report for non-medical prescribers. Report to include list of medications prescribed/issued by NMPs.	Yes			Lead Pharmacist - tbc	Monthly Report to be presented at the directorate governance meeting.	Lead Pharmacist for Primary Care

Non-Medical Prescribers to have one hour each month allocated for clinical supervision with Pharmacist/GP. To analyse report and reflect on practice.		Current service review in progress by CH. Meeting arranged with Pharmacist Feb to update on CQC report.	1st April19	Lead Pharmacist - tbc	Lead Pharmacist to present monthly report to governance meeting. Non- Medical Prescriber to demonstrate compliance during monthly 1:1 sessions with managers and appraisals.	Katie Welborn -SM, Lead Pharmacist.
4) CQC Recommendation	**Compliance**	**Comments**	**Completed Date**	**Action**	**Monitoring Plan by DMT.**	**Guidance Lead**
Improve monitoring of patients on high risk medication.	**Completed**	Audit has been undertaken by MS/AB.		Audit to be presented in the Feb governance meeting.	Monitoring Plan by DMT in the governance meeting.	Julian Parkes - CD, Lead Pharmacist.
Audit of high mediations to be presented at the next governance meeting.	**Yes**		**28/02/2019**		Monitoring Plan by DMT.	Julian Parkes - CD, Lead Pharmacist.
Develop Standard Operation Policy (SOP) for the monitoring of patients on high risk medications.		Pharmacist service review in-progress.		ıdentify Lead Pharmacist for Primary Care. Review current processes and develop SOP for the monitoring of high risk medications.	Monitored by DMT	Lead Pharmacist, Julian Parkes -CD
SOP to be implemented across Primary Care.						Lead Pharmacist

Monthly compliance audit to be presented in the DMT governance meeting.					Monitoring Plan by DMT.	Lead Pharmacist, Julian Parkes - CD.
5) CQC Recommendation	**Compliance**	**Comments**	**Completed Date**	**Action**	**Monitoring Plan by DMT.**	**Guidance Lead**
Improve communication and information given to staff.	Completed	Monthly 1:1 meetings held with Practice Managers and Practice Nurses. Monthly meetings for Practice Managers and Practice Nurses. Quarterly Newletters sent to staff, Newsletter sent to all staff from RWT. Quarterly away days for all staff. Visits to Practices from the Senior Leadership Team. Quality improvement training to be delivered to PN'S (supporting with engagement).	31/01/2019	Continue with current processes. Review staff survey and develop action plan. Embed listening into action into Primary Care. Empower practice staff to implement change through quality improvement methodology.	HR Complaints, Staff Survey, Sickness Rate.	Julian Parkes CD, Charlotte Hill DDM, Katie Welborn SM
6) CQC Recommendation	**Compliance**	**Comments**	**Completed Date**	**Action**	**Monitoring Plan by DMT.**	**Guidance Lead**
Identify Carers and establish what support they may require.	Completed	LTC Care plans amended. Practice managers trained in care navigation and social prescribing. Working with community connections.	**31/01/2019**	Continue with current processes.	Report to be presented to operational meeting - monthly.	Maxine Richuss - ADM

Yes