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Bracknell Forest Council

HEALTH OVERVIEW AND SCRUTINY PANEL

19 AUGUST 2013

SUPPLEMENTARY PAPERS

TO: ALL MEMBERS OF THE HEALTH OVERVIEW AND SCRUTINY PANEL

The following papers have been added to the agenda for the above meeting.

These were not available for publication with the rest of the agenda.

Alison Sanders
Director of Corporate Services

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OUTCOME 1: Respecting and involving people who use services
CQC Judgement: Moderate Concern - There were insufficient arrangements for ensuring patients' dignity, privacy and independence. The trust did not encourage patients, or those acting on their behalf, to understand the treatment choices available to them. The trust did not give patients, or those acting on their behalf, an opportunity to express their views about what was important to them in relation to their care or treatment.

Action ref.	Action Required & What Action Intends to Achieve	Measurable Outcome of Action/ Evidence of Action	Resp.	Due Date	Resource Implication/ Cost	Ongoing Assurance Processes	Update on Progress with Actions as at *19/7/13*
1.1	Redesign the A&E department to increase the numbers of A&E beds available to support staff in maintaining privacy and dignity through mitigating the need for 'stacking'/'doubling up'. (This involves increasing the number of beds for adults by circa 40% and Children by circa 30%)	• Plans for redevelopment • Approval of plans and capital spend • Project Plan • Completion of building work	DoFa	25 Oct	£1.2m capital	• Emergency Care Pathway improvement plan and performance report monitored by the trust executive	• Plans and capital spend agreed by trust finance & business development committee
1.2	Redesign the A&E department to eliminate the need for patients to enter the building via the resuscitation area to support staff in maintaining privacy and dignity.	• Plans for redevelopment • Approval of plans and capital spend • Project Plan • Completion of building work	DoFa	25 Oct	£1.2m capital	• Emergency Care Pathway improvement plan and performance report monitored by the trust executive	• Plans and capital spend agreed by trust finance & business development committee
1.3	Enhance direct nursing leadership/management on the Emergency Department Decision Unit (EDDU) by appointing a dedicated Junior Ward	• Job Description • Appointment of Ward Manager	COO	30 Aug	£40k recurrent revenue	• Each Ward Matron (or nurse in charge in their absence) to undertake daily quality monitoring and record on ward quality return	

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	Manager, who will be responsible for ensuring standards of nursing care are maintained, including privacy and dignity.					compliance with nursing care standards (taking remedial action to make improvements if required). This return will be monitored by the Compliance team lead by the newly appointed Associate Director of Clinical Compliance and Lead Nurses. • The by the compliance team lead by the newly appointed Associate Director of Clinical Compliance will review ward matron returns and take action (with the lead nurses) to fix problematic areas that cannot or have not been remedied at ward level. • The by the compliance team lead by the newly appointed Associate Director of Clinical Compliance will ensure that a 'peer review' audit of each ward area (independent to the ward, either led by the Associate Director or a lead nurse from a different clinical area) is undertaken to verify the matron returns and to provide further assurance of action/compliance. This will scrutinise ward compliance, highlight concerns and drive forward action as a result • In addition to this, members of the Board and divisional senior	

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						management team will each, accompanied by a member of the senior nursing team, undertake a ward audit using the standard checklist each month with results being reported to the Associate Director of Clinical Compliance.	
1.4	Close the Medical Investigations Day Unit (MIDU); Rehabilitation / Physiotherapy; Discharge Lounge area as an escalation area to support staff in maintaining privacy and dignity.	• MIDU; Rehabilitation / Physiotherapy and Discharge Lounge not used as an escalation areas	COO	12 July	N/A	• The controlled use of approved escalation areas will be monitored in line with the revised surge escalation policy	• Complete
1.5	Purchase and provide new gowns designed to enhance dignity, and provide appropriate patient nightwear if required to maintain patient privacy and dignity.	• Available 'new' gowns • Available nightwear	DoFa	5 Aug	Within current plans	• Patient privacy and dignity will be monitored via the ward level governance compliance process described in 1.3 above.	
1.6	Develop a patient involvement policy and an associated implementation plan that will include a comprehensive training programme aimed at improving communication between staff and patients, and their relatives. This will focus on core issues including communicating treatment/care plans, outcomes of diagnostic tests and estimated date of	• Policy • Implementation Plan • Training Programme	DoN	13 Sep	£40k one off cost for development programme	• Communication between staff and patients, and their relatives will be monitored via the ward level governance compliance process described in 1.3 above	

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	discharge. The policy, approach and training will draw on the evidence base in the NICE Clinical Guideline – 'Patient Experience in Generic Terms' and will involve patients and their relatives in its development. This work plan intends to equip staff to encourage patients, or those acting on their behalf, to understand the treatment choices available to them, and have an opportunity to express their views about what was important to them in relation to their care or treatment.						

OUTCOME 4: Care and welfare of people who use services
CQC Judgement: Moderate Concern - The trust did not ensure patients were protected against the risks of receiving care or treatment that was inappropriate or unsafe. Patients' needs were not always assessed and the delivery of care did not always meet patients' individual needs. The welfare and safety of patients was not always ensured.

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4.1	Develop an effective Capacity Plan to ensure that the Trust has sufficient physical, equipment, bed and staff capacity to meet expected non-elective and elective activity demand. This is intended to ensure patients care needs are adequately met by moving on from A&E promptly thus reducing any potential delays in their care and where required are placed on a ward specific to their needs.	• Capacity Plan • Implementation actions	DCEO	18 Oct	£30k one off cost for external consultancy	• Implementation of the capacity plan will be monitored by the trust executive team	• First cut of elective and non elective numbers modelled being reviewed by ex Medical Director
4.2	Redesign the A&E department to increase the numbers of A&E beds available, mitigating the need for 'stacking'/'queuing', thus enabling patients to get prompt appropriate care in A&E. (This involves increasing the number of beds for adults by circa 40% and Children by circa 30%)	• Plans for redevelopment • Approval of plans and capital spend • Project Plan • Completion of building work	DoFa	25 Oct	£1.2m capital	• Emergency Care Pathway improvement plan and performance report monitored by the trust executive	• Plans and capital spend agreed by trust finance & business development committee

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4.3	Review and establish the required staffing to meet the demand in A&E thus minimising delays to assessment and treatment and ensure appropriate care can be provided in A&E.	• Staffing review document • Recruitment to vacant/new post	COO	27 Sep	Recurrent revenue cost to be determined estimated at circa £400k	• Emergency Care Pathway improvement plan and performance report monitored by the trust executive	
4.4	Minimise the time to treatment in A&E by implementing the trusts Urgent Care action plan. Specifically implementing Rapid Assessment and Treatment (RAT) for “majors" patients and See and Treat for patients with minor injuries and illnesses. This intends to minimise delays to assessment and treatment so that patients can have their care needs met in a timely and appropriate manner.	• Revised model of care in A&E	DCEO	25 Oct	N/A	• Emergency Care Pathway improvement plan and performance report monitored by the trust executive	
4.5	Review current nursing care planning, assessment and progress recording documentation and develop a revised systematic process for assessment, care planning and documentation of care. This revised process and paperwork will be described in a documentation policy; with a system for implementation in the clinical setting through education, audit and support. This action is intended to ensure patient’s needs are assessed and the delivery of care meets	• Paperwork and process for planning, assessing and recording nursing care • Training programme	DoN	13 Sep	Within current plans	• Each Ward Matron (or nurse in charge in their absence) to undertake daily quality monitoring and record on ward quality return compliance with nursing care standards (taking remedial action to make improvements if required). This return will be monitored by the Compliance team lead by the newly appointed Associate Director of Clinical Compliance and Lead Nurses. • The by the compliance team lead	

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	patients' individual needs.					by the newly appointed Associate Director of Clinical Compliance will review ward matron returns and take action (with the lead nurses) to fix problematic areas that cannot or have not been remedied at ward level. • The by the compliance team lead by the newly appointed Associate Director of Clinical Compliance will ensure that a 'peer review' audit of each ward area (independent to the ward, either led by the Associate Director or a lead nurse from a different clinical area) is undertaken to verify the matron returns and to provide further assurance of action/compliance. This will scrutinise ward compliance, highlight concerns and drive forward action as a result • In addition to this, members of the Board and divisional senior management team will each, accompanied by a member of the senior nursing team, undertake a ward audit using the standard checklist each month with results being reported to the Associate Director of Clinical Compliance.	
4.6	A review of ward management to	• Review report	DoN	27	£30k one off	• The improvement plan will be	

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	assess the underlying causes of poor practice at ward level. The subsequent ward management improvement plan will outline the Trust's plans and key milestones underpinning improvement. The aim of this action is to ensure patients are protected against the risks of receiving care or treatment that is inappropriate or unsafe.	• Improvement plan		Sep	cost for review	monitored by the trust executive.	
4.7	Training in dementia will be re-launched, with an emphasis on the need for increase usage of the Trust's in-house Mental Health team. This will be supported by the use of the Sunflower symbol to enable staff to easily identify patients with dementia who need additional support. This action intends to improve the standards of care for patients with dementia.	• Training programme • Notification system	DoN	2 Aug	Within current plans	• KPI (to be reported up to the Board and also monitored at ward level) that all patients over the age of 75 will be assessed for dementia within 72 hours of admission.	
4.9	Promote and adopt dementia friendly environments around the Trust to improve patient experience for those being cared for with dementia, delirium and confusion. This will include improved signage to aid orientation and promote patient independence.	• Environmental changes	DoN	24 Sep	Within current plans	• KPI (to be reported up to the Board and also monitored at ward level) that all patients over the age of 75 will be assessed for dementia within 72 hours of admission.	

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4.10	Develop and implement a Surge Escalation Policy/Plan that will prioritise the use of escalation areas on a 'risk-assessed' basis clarifying what areas can be used and for whom; and what needs to be in place to open the area to provide an appropriate level of care.	• Surge escalation policy and associated documentation • De-escalation of use as inpatient areas of: Rehabilitation / Physiotherapy area MIDU Discharge Lounge.	COO	6 Sep	Within current plans	• The trust executive will receive a monthly update on the use of escalation areas which will monitor compliance with risk assessments to mitigate any risks identified in using an area that is not normally bedded. • When it is agreed that an area must be opened in order to satisfy capacity demands, continued use must be formally reviewed and signed off by the COO or Deputy COO on a daily basis, based upon the ongoing capacity requirement *and* any changes in the risk assessments undertaken, as outlined above an audit trail will be maintained and summary reports will be provided to the trust executive. • All escalation areas have now been closed. In future, in advance of the establishment of Ward 17, escalation areas will only be used on a fully 'risk assessed' basis, underpinned by the interim Surge Escalation Plan.	• MIDU; Rehabilitation / Physiotherapy and Discharge Lounge not used as an escalation areas.
4.11	Provide an additional 28 beds through renovating and then establishing Ward 17 to be used as the 'first stage' escalation area within new Surge	• Plans for redevelopment • Approval of plans and capital spend	DoFa	17 Sep	£ 700k capital	• Emergency Care Pathway improvement plan and performance report monitored by the trust executive	• Plans and capital spend agreed by trust finance & business

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	Escalation Plan in order to accommodate excess patient activity. This will provide a standard ward environment for patients where an appropriate level of care can be provided.	• Project Plan • Completion of building work					development committee
4.12	Undertake audit/review of all call bells on wards to ensure all defective/broken bells are identified and subsequently either repaired or replaced. These actions aim to ensure that the delivery of care meet patients' individual needs.	• Report on call bell replacement • Functioning call system • Manual call bells available	DoFa	12 Aug	Within current plans	• Ongoing patient access to call bells will be a key part of the Ward-Level Governance Compliance checks described in 4.5 above. • Manual call bells will be available.	
4.13	The expectation that Ward matrons will ensure call bells are in reach of patients and that patients get prompt assistance when requested will be reinforced as part of the review of roles and responsibilities. These actions aim to ensure that the delivery of care meet patients' individual needs.	• Communication of expectation to all ward matrons	DoN	2 Aug	Within current plans	• Ongoing patient access to call bells will be a key part of the Ward-Level Governance Compliance checks described in 4.5 above. • Manual call bells will be available.	
4.14	Ensure that each ward uses a standardised system for establishing 'who is in charge' (including when the relevant matron is away from work), using ward boards and clearly identifiable badges. These actions aim	• Easily identifiable person in charge of ward	DoN	9 Aug	Within current plans	• Visibility and clarity of the nurse in charge will be monitored via the ward level governance compliance process described in 4.5 above.	

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	to ensure that the delivery of care meet patients' individual needs.						
4.15	Dedicated Chief Executive e-mail to be set-up for frontline staff to raise concerns related to the safety or quality of patient care and to share good practice.	• Email in place • Responses received • Changes made	DoN	18 July	N/A	• This will be monitored by the corporate nursing team who will ensure that all e-mails get a response within 2 working days.	Complete

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OUTCOME 8: Cleanliness and infection control
CQC Judgement: Moderate Concern - The trust did not ensure patients, staff, and others were protected against identifiable risks of acquiring a healthcare associated an infection through the maintenance of appropriate standards of cleanliness and hygiene in relation to the hospital environment and equipment.

Action ref.	Action Required & What Action Intends to Achieve	Measurable Outcome of Action/ Evidence of Action	Resp.	Due Date	Resource Implication/ Cost	Ongoing Assurance Processes	Update on Progress with Actions as at *19/7/13*
8.1	Establish a 'fast track' process, whereby all 'high risk' outcomes identified by the Infection Control team through ward area audits are escalated immediately to the Medical Director (as DIPC) in order for urgent action to be taken. This is intended to ensure that where concerns of this level are identified that they are addressed immediately to protect people from the risk of infection.	• Audit report updates will indicate a timely response to all 'high risk' outcomes	MD	31 July	N/A	• Monitoring of progress in responding to audits at the Infection Control Committee; the Patient Safety Group; and the Healthcare Governance Committee	
8.2	The outcomes of all scheduled infection control audits to be reported through the Infection Control Committee to the Patient Safety Group, with upwards reporting to the Healthcare Governance Committee. This is intended to ensure that there is enhanced monitoring of timely actions to protect people from the risk of infection.	• Audit report updates will indicate a timely response to all 'high risk' outcomes	MD	31 July	N/A	• Monitoring of progress in responding to audits at the Infection Control Committee; the Patient Safety Group; and the Healthcare Governance Committee	
8.3	Establishment of new Infection Control Audit dashboard, reported to the Trust	• Infection control dashboard	MD	5 Sep	N/A	• Infection control dashboard will be monitored by the trust board	

Action ref.	Action Required & What Action Intends to Achieve	Measurable Outcome of Action/ Evidence of Action	Resp.	Due Date	Resource Implication/ Cost	Ongoing Assurance Processes	Update on Progress with Actions as at *19/7/13*
	Board each month. This is intended to ensure that there is enhanced monitoring of timely actions to protect people from the risk of infection.	received by the trust board					
8.4	Commence a full deep clean of all ward areas aimed at ensuring satisfactory standards of cleanliness can be maintained from a clear baseline. This is aimed at ensuring patients are cared for in an appropriate environment.	• Recruitment to two deep clean teams • Commence deep clean	DoFa	23 July	£40k one off cost to pump prime this work	• Ward cleanliness will be monitored via the ward level governance compliance process described in 8.8 below.	• Team recruited
8.5	Complete a 'bed head' audit to identify services and repairs required and implement a repair and replacement plan. In parallel appoint a Site Management team to ensure that estate/facility related problems are addressed in a timely fashion. This is aimed at ensuring patients are cared for in an appropriate environment.	• Daily reports on bed head audit • Bed head repairs and replacements • Appoint manger for site management team	DoFa	19 July	£20k in year cost	• The state of repair on wards will be monitored via the ward level governance compliance process described in 8.8 below.	• Site Manager appointed
8.6	Refurbishment schedule to be reviewed and implemented, prioritising areas (i.e. toilets in rehabilitation for outpatients) most affected by wear and tear as highlighted through capital planning programme and the six facet survey. This is aimed at ensuring patients are cared for in an appropriate environment.	• Review and reprioritisation of improvement schemes at capital planning group monthly.	DoFa	5 Aug	Within capital programme	• Monthly capital planning group will monitor progress hospital refurbishment programme.	

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8.7	Increase available storage space through the redesign of A&E which includes a doubling of storage space. A review of ward storage space will also be undertaken to identify the best storage space for general and patient equipment. Temporary storage will also be provided in adjacent areas to wards/ departments if required. This action intends to minimise the risk to cleanliness and contamination.	• Ward by ward report on required storage space • Options to meet requirements in place	DoFa	25 Oct	Within capital programme and A&E development costs	• General cleanliness and safe storage will be monitored via the ward level governance compliance process described in 8.8 below.	
8.8	Development and re-launch of enhanced cleaning schedule which will be disseminated to all ward matrons and lead nurses. The monitoring of which is intended to support the protection of people from the risk of infection.	• Cleaning schedules on all wards regularly completed	DoN	2 Aug	N/A	• Each Ward Matron (or nurse in charge in their absence) to undertake daily quality monitoring and record on ward quality return compliance with nursing care standards (taking remedial action to make improvements if required). This return will be monitored by the Compliance team lead by the newly appointed Associate Director of Clinical Compliance and Lead Nurses. • The by the compliance team lead by the newly appointed Associate Director of Clinical Compliance will review ward matron returns and take action (with the lead nurses) to fix problematic areas that cannot or have not been remedied at ward level. • The by the compliance team lead by the newly appointed Associate	

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						Director of Clinical Compliance will ensure that a 'peer review' audit of each ward area (independent to the ward, either led by the Associate Director or a lead nurse from a different clinical area) is undertaken to verify the matron returns and to provide further assurance of action/compliance. This will scrutinise ward compliance, highlight concerns and drive forward action as a result • In addition to this, members of the Board and divisional senior management team will each, accompanied by a member of the senior nursing team, undertake a ward audit using the standard checklist each month with results being reported to the Associate Director of Clinical Compliance.	
8.9	Re-launch of process for the raising of urgent concerns with regard to ward storage/defective facilities issues to Estates Department. This is aimed at ensuring patients are cared for in an appropriate environment.	• Clear process for raising of urgent concerns communicated to all staff	DoFa	5 Aug	N/A	• Monthly facilities KPIS for response time etc. will be monitored by trust executive.	
8.10	Hand hygiene training to be re-targeted to ward areas of low compliance. This action is intended to protect people from the risk of	• Improved compliance with hand hygiene	MD	2 Aug	N/A	• Monitoring of progress in responding to audits at the Infection Control Committee; the Patient Safety	

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	infection.	standards				Group; and the Healthcare Governance Committee.	

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OUTCOME 9: Management of medicines
CQC Judgement: Moderate Concern - The trust did not protect service users against the risks associated with the unsafe storage of medicines.

Action ref.	Action Required & What Action Intends to Achieve	Measurable Outcome of Action/ Evidence of Action	Resp.	Due Date	Resource Implication/ Cost	Ongoing Assurance Processes	Update on Progress with Actions as at *19/7/13*
9.1	All lockers to store patients own drugs (POD lockers) will be repaired and replaced if required. This is intended to ensure patients are protected against the risks associated with medicines because of drug storage arrangements.	• Audit of all wards identifying need for repair and replacement • Repair and replacement undertaken	DoFa	9 Aug	Within current plans	• Site audits undertaken by the Facilities Site Managers will be monitored by the trust executive.	
9.2	There will be an audit of all ward fridges to ensure they are lockable and have thermometers and obtain replacements in any instance where this is not the case. As part of this audit the system and process for monitoring temperatures will be reviewed and changes made where required. This is intended to ensure patients are protected against the risks associated with medicines because of drug storage arrangements.	• Audit of all wards identifying need for replacements • Replacement undertaken • System and process for monitoring will be included in the ward level governance compliance process described opposite	DoN	5 Aug	Within current plans	• Each Ward Matron (or nurse in charge in their absence) to undertake daily quality monitoring and record on ward quality return compliance with nursing care standards (taking remedial action to make improvements if required). This return will be monitored by the Compliance team lead by the newly appointed Associate Director of Clinical Compliance and Lead Nurses. • The by the compliance team lead by the newly appointed Associate Director of Clinical Compliance will review ward matron returns and take action (with the lead nurses) to fix	

Action ref.	Action Required & What Action Intends to Achieve	Measurable Outcome of Action/ Evidence of Action	Resp.	Due Date	Resource Implication/ Cost	Ongoing Assurance Processes	Update on Progress with Actions as at *19/7/13*
						problematic areas that cannot or have not been remedied at ward level. • The by the compliance team lead by the newly appointed Associate Director of Clinical Compliance will ensure that a 'peer review' audit of each ward area (independent to the ward, either led by the Associate Director or a lead nurse from a different clinical area) is undertaken to verify the matron returns and to provide further assurance of action/compliance. This will scrutinise ward compliance, highlight concerns and drive forward action as a result • In addition to this, members of the Board and divisional senior management team will each, accompanied by a member of the senior nursing team, undertake a ward audit using the standard checklist each month with results being reported to the Associate Director of Clinical Compliance.	
9.3	The Director of Nursing will write to all Matrons identifying and reinforcing their responsibilities in relation to treatment room safety, security and fitness for purpose. This aims to ensure patients are protected against the risks associated with	• Clear communication of expectations to all nurses.	DoN	26 July	N/A	• Treatment room safety, security and fitness for purpose will be monitored via the ward level governance compliance process described at 9.2 above.	

Action ref.	Action Required & What Action Intends to Achieve	Measurable Outcome of Action/ Evidence of Action	Resp.	Due Date	Resource Implication/ Cost	Ongoing Assurance Processes	Update on Progress with Actions as at *19/7/13*
	the unsafe storage of medicines.						
9.4	The Director of Nursing will write to all Nurses identifying and reinforcing their responsibilities in relation to Medicines Management enclosing the NMC Standards for Medicines Management and the Trust Policy for Medicines Management (TPP 109). Nurses will be afforded the opportunity for remedial refresher training if required. This is intended to ensure people are given medicine they need when they need it and in a safe way.	• Clear communication of expectations to all nurses. • Attendance at refresher training as required.	DoN	26 July	N/A	• Medicines management standards will be monitored via the ward level governance compliance process described at 9.2 above.	
9.5	Their will be a review of Standard Operating Procedures (SOPs) for medicines management and a task and finish group consisting of senior nurses and pharmacists will identify gaps and develop and communicate clear SOPs as required. This is intended to ensure patients are protected against the risks associated with medicines because of drug storage arrangements.	• Revised operating procedures where required.	DoN	30 Aug	N/A	• Medicines management standards will be monitored via the ward level governance compliance process described at 9.2 above.	

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OUTCOME 13: Staffing
CQC Judgement: Moderate Concern - The trust did not take appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced persons employed to provide care and treatment to patients.

Action ref.	Action Required & What Action Intends to Achieve	Measurable Outcome of Action/ Evidence of Action	Resp.	Due Date	Resource Implication/ Cost	Ongoing Assurance Processes	Update on Progress with Actions as at *date*
13.1	A comprehensive reassessment of patient acuity and/or dependency to inform the trusts decision making on staffing and workforce by using AUKUH nursing dependency tool (Safer Nursing Care Tool) to be used during the last two weeks in July to identify any changes to baseline staffing requirements to meet patient need. On a daily basis if a ward matron believes that the acuity of patients changes, then the tool should be used alongside their professional judgement to determine there are sufficient numbers of suitably qualified, skilled and experienced persons employed to provide care and treatment to patients.	• Refreshed nursing staff baseline and process for daily flexibility	DoN	2 Aug	N/A	• Trust executive and trust board will monitor staffing metrics monthly.	
13.2	From this review a 'best practice' ward establishment template for each ward which incorporates an	• Baseline staffing requirements. Describe by ward.	DoN	9 Aug	N/A	• Trust executive and trust board will monitor staffing metrics monthly	

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	understanding of the baseline staffing levels for each ward will be developed. Templates will be approved by the Associate Directors of Professions/Nursing for each Division and HR. The template will include the required number of trained and untrained staff per shift, per day of the week. This action intends to ensure that there are sufficient numbers of suitably qualified, skilled and experienced persons employed to provide care and treatment to patients.						
13.3	Enhance direct nursing leadership/management on the Emergency Department Decision Unit (EDDU) by appointing a dedicated Junior Ward Manager; who will be responsible for ensuring standards of nursing care are maintained and directly supervised.	• Job Description • Appointment of Ward Manager	COO	30 Aug	£40k recurrent revenue	• Each Ward Matron (or nurse in charge in their absence) to undertake daily quality monitoring and record on ward quality return compliance with nursing care standards (taking remedial action to make improvements if required). This return will be monitored by the Associate Director of Clinical Compliance and Lead Nurses. • The Associate Director of Clinical Compliance	

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						will review ward matron returns and take action (with the lead nurse) to fix problematic areas that cannot or have not been remedied at ward level. • The Associate Director of Clinical Compliance will ensure that a 'peer review' audit of each ward area (independent to the ward, either led by the Associate Director or a lead nurse from a different clinical area) is undertaken to verify the matron returns and to provide further assurance of action/compliance. This will scrutinise ward compliance, highlight concerns and drive forward action as a result • In addition to this, members of the Board and divisional senior management team will each, accompanied by a member of the senior nursing team, undertake a ward audit	

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						using the standard checklist each month with results being reported to the Associate Director of Clinical Compliance.	
13.4	Develop and implement a Surge Escalation Policy/Plan that will prioritise the use of escalation areas on a 'risk-assessed' basis clarifying what areas can be used and for whom and what needs to be in place to open the area and provide an appropriate level of care. This plan will describe safe staffing levels to be agreed for individual escalation areas taking into consideration agreed patient acuity and dependency levels for each area. Clinical teams to be established for each area to ensure continuity of care is provided, including explicit ratio of Trust staff to temporary staff (if required).	• Surge escalation policy and associated documentation • De-escalation of use as inpatient areas of: Rehabilitation / Physiotherapy area MIDU Discharge Lounge.	COO	6 Sep	Within current plans	• The trust executive will receive a monthly update on the use of escalation areas which will monitor compliance with risk assessments to mitigate any risks identified in using an area that is not normally bedded.	• MIDU; Rehabilitation / Physiotherapy and Discharge Lounge not used as an escalation areas
13.5	To continue and enhance the active trust wide recruitment drive to minimise the use of temporary staff and ensure that the correct number of appropriately skilled and experienced staff are available to	• Recruitment plan	DoHR	24 Sep	Within current plans	• Trust executive and trust board will monitor staffing metrics monthly.	

Action ref.	Action Required & What Action Intends to Achieve	Measurable Outcome of Action/ Evidence of Action	Resp.	Due Date	Resource Implication/ Cost	Ongoing Assurance Processes	Update on Progress with Actions as at *date*
	meet patient's needs.						
13.6	Develop an effective Capacity Plan to ensure that the Trust has sufficient physical, equipment, bed and staff capacity to meet expected non-elective and elective activity demand. Part of this plan intends to ensure that the correct number of appropriately skilled and experienced staff are available to meet patient's needs.	• Capacity Plan • Implementation actions	DCEO	18 Oct	£30k one off cost for external consultancy	• Implementation of the capacity plan will be monitored by the trust executive team	
13.7	To review the current approaches to retention and engagement and develop a retention and engagement strategy and implementation plan that aims to ensure that the correct number of appropriately skilled and experienced staff are available to meet patient's needs.	• Retention and engagement strategy • Implementation actions	DoHR	24 Sep	Plan is likely to need resourcing	• Trust executive and trust board will monitor staffing metrics monthly.	
13.8	Clinical Rota Policy to be developed and implemented, with explicit rules and clear expectations as to the development, management and publication of rotas. The Policy will also describe the internal financial and quality governance arrangements to	• Clinical rota policy • Rotas with appropriate planned staffing	COO	10 Sep	N/A	• Trust executive and trust board will monitor staffing metrics monthly.	

Action ref.	Action Required & What Action Intends to Achieve	Measurable Outcome of Action/ Evidence of Action	Resp.	Due Date	Resource Implication/ Cost	Ongoing Assurance Processes	Update on Progress with Actions as at *date*
	ensure appropriate clinical skill mix based on acuity is maintained.						

OUTCOME 16: Assessing and monitoring the quality of service provision
CQC Judgement: Major Concern - From the evidence that the CQC note in paragraphs 1-26 in the warning notice dated the 21st June 2013 they judged that the Trust failed to ensure that systems in place to regularly assess and monitor the quality of services provided in the carrying on of the regulated activity, enable the management of risk relating to the health, safety and welfare of service users and others who may be at risk to be managed effectively.

Action ref.	Reference Within Report	Action Required	Action to Date/Evidence	Due Date	Resp.	Ongoing Assurance Processes	Resource Required
16.1	**Effectiveness of Board/Senior Management at Driving Action/Mitigation Identified Through Risk Processes** *In focusing on the management of its capacity pressures, we found the trust failed to respond to concerns about poor patient experiences and to patient safety risks which were identified by staff. The risk assurance framework showed "concerns were raised by the [physiotherapy team] regarding [the] safety and dignity of in and outpatients within the [rehabilitation] unit" as a result of using the unit as an escalation area. The risk was added to the framework in April 2013. Action taken was recorded as "all risk assessments completed" and dated 5 April 2013.*	1. The Executive Board should, on a monthly basis, take responsibility for the detailed scrutiny of the Trust-wide Risk Assurance Framework (RAF), receiving assurance that the risk mitigation plans are sufficient and where not, requesting further assurance and action. The emphasis will be upon challenge and for agreeing urgent actions for implementation. The Executive Board should set expectations for the completion of mitigating actions and ensure these are followed-up. This will need to occur as part of a 'Risk Scrutiny Forum' held at the commencement of each Executive Board meeting. 2. Each Division/Directorate Risk Assurance Framework document will be refreshed during July 2013, ensuring that the RAF as a whole	Risk Scrutiny Forum Action Log. 'Refresh' meetings held with all Divisional/ Directorate leads. New document to be submitted to July Audit	From July 2013 Executive Board By 26 July 2013	Director of Corporate Affairs/ Chief Executive Director of Corporate Affairs	1. Risk Scrutiny Forum actions to be circulated to Trust Board. 2. Refreshed RAF to be received by July Audit Committee and Executive Board and August Trust Board.	Existing resource only Existing resource only

Action ref.	Reference Within Report	Action Required	Action to Date/Evidence	Due Date	Resp.	Ongoing Assurance Processes	Resource Required
		remains up-to-date, relevant and truly reflective of organisational risk.	Committee.				
16.2	**Governance Relating to the Use of Escalation Areas** *On 21 May 2013 we requested the trust provide us with the protocols it used to determine which areas were to be used as escalation areas and how they should be risk assessed. We were told during interviews on 13 May 2013 with trust senior managers that these protocols existed. On 21 May 2013, we sent an email requesting a copy of the trust's protocols for identifying and risk assessing escalation areas. The trust responded to our request on 22 May 2013 via email stating "opening escalation areas in all cases requires Executive Director approval and patient safety considerations are the most important factor in such judgments, with advice and assessment being sought from the Director of Nursing as necessary. However, we do not have 'templates' for this."*	1. Permanently close previously used escalation areas to admissions (Rehabilitation, Theatre Admissions Lounge, MIDU etc.). 2. Development of a Surge Escalation Plan, that incorporates a template which must be completed, in advance of usage, for each area, involving the following form of risk assessments: - Fire - H&S - Infection Control - Staffing - Availability of Medical Equipment & Facilities The Plan will also outline the: - Escalation Trigger points; - Pre-escalation usage actions to be taken (all Divisions); - Opening order of	Old escalation areas no longer in use. Surge Escalation Plan	By end July 2013 By end August 2013, but for interim surge escalation guidance to be issued by end July 2013.	Chief Operating Officer Chief Operating Officer	Board to be kept updated on monthly basis as to areas of escalation in use. The Business Safety Group to quality assure suite of risk assessments for each potential escalation area.	This has been enabled by investing in additional 'front end' capacity. Existing resource only

Action ref.	Reference Within Report	Action Required	Action to Date/Evidence	Due Date	Resp.	Ongoing Assurance Processes	Resource Required
		escalation areas (based upon risk assessments above); - Actions to be taken prior to requesting divert (internal); - Actions to be taken prior to requesting a divert (external); - Process for requesting a divert.					
		3. When it is agreed that an area must be opened in order to satisfy capacity demands, continued use must be formally reviewed and signed off by the COO or Deputy COO on a daily basis, based upon the ongoing capacity requirement *and* any changes in the risk assessments undertaken, as outlined above.	Daily Escalation Usage 'sign-off' sheet.	By end July 2013, based upon interim surge escalation guidance	Chief Operating Officer	Daily decision to be clearly written and disseminated to key staff: bed managers, managers/ directors on call etc.	Existing resource only
		4. Based upon the risk assessments identified above, there will be a clear 'prioritisation' list of which escalation areas are used above others, in addition to a clear position on which areas will not be used to accommodate patients except in the event of a major incident.	Prioritisation list to be disseminated to on-call managers & Directors and also used during working hours by bed management team.	By end July 2013, based upon interim surge escalation guidance	Chief Operating Officer	This prioritisation will be a key aspect of the Surge Escalation Plan.	Existing resource only
		5. There are plans to develop and then establish Ward 17 to be used as the 'first stage' escalation area;	Ward 17 to be tested through Escalation Usage Protocol.	By end September 2013	Director of Estates & Non-	Progress in development of Ward 17 to be reported	£700k Capital funding

Action ref.	Reference Within Report	Action Required	Action to Date/Evidence	Due Date	Resp.	Ongoing Assurance Processes	Resource Required
		this will provide a far more suitable environment for patients in the event that additional temporary capacity is required.			Clinical Services	directly to the Board.	allocated
16.3	**Governance Relating to the Escalation of Infection Control Audits/Concerns** *An infection control standards audit of A&E, completed by the hospital in July 2012, showed an overall compliance with infection control standards of 56%. Concerns were identified regarding the cleanliness of equipment and the environment; lack of a cleaning schedule for trolleys; resuscitation equipment not being checked once a week rather than daily; inappropriate and unsafe storage of medicines; and IV fluids stored unsupervised in an open corridor.*	1. *Assuming 'low risk' findings:* The outcomes of all scheduled infection control audits to be reported by the Infection Control Committee directly to the Healthcare Governance Committee- a Board Committee- in future (rather than via the Patient Safety Group). 2. However, all 'high risk' outcomes identified by the Infection Control team through ward area audits to be escalated immediately to the Medical Director (as DIPC) in order for urgent escalation and action to be taken.	Reporting structure in place. DIPC on Board identified.	From July 2013 From July 2013	Medical Director Medical Director	The upwards information flow relating to infection control audits will be tested by the Healthcare Governance Committee. Urgent infection control audit outcomes to be brought to the direct attention of the Executive Board by the Medical Director as DIPC.	Existing resource only Existing resource only
16.4	**Clinical Stock Shortages** *Other reports from the infection*	1. Rewrite and circulate process for the raising of urgent concerns with	Urgent stock request form to be developed.	From August 2013	Director of Estates &	Estates & Facilities team to keep a log of	Existing resource

Action ref.	Reference Within Report	Action Required	Action to Date/Evidence	Due Date	Resp.	Ongoing Assurance Processes	Resource Required
	control team dated 22 and 29 April 2013 identify on-going concerns about shortages of stock and medical supplies, bed linen.	regard to basic clinical stock.			Non-Clinical Services	urgent ward requests and to have responsiveness reviewed as an internal KPI, reported through the Operational Performance Report.	only
16.5	**Governance Relating to the Escalation of Fire Audits/Concerns** *A fire risk assessment, undertaken by the trust's health and safety officer (fire) and dated 4 April 2013, identified inadequate fire safety arrangements for in-patients accommodated in the rehabilitation / physiotherapy outpatients area.*	1. *Assuming 'low risk' findings:* All internal fire risk assessment activity to be reported to the Trust Business Safety Committee, with upwards reporting to the Healthcare Governance Committee.	Reporting structure in place.	From July 2013	Director of Corporate Affairs	The Business Safety Committee will review non-urgent fire audit findings and upwards report to the Healthcare Governance Committee.	Existing resource only
		2. All 'high risk' outcomes identified by fire risk assessment to be escalated immediately to the Director of Estates & Non-Clinical Services in order for urgent action to be taken.	Director of Estates & Non-Clinical Services to report directly to Executive Board / Trust Board on urgent issues and to take appropriate action.	From July 2013	Director of Estates & Non-Clinical Services	Urgent fire risk assessment outcomes to be brought to the direct attention of the Executive Board by the Director of Estates & Non-Clinical Services.	Existing resource only

Action ref.	Reference Within Report	Action Required	Action to Date/Evidence	Due Date	Resp.	Ongoing Assurance Processes	Resource Required
16.6	**Ward-Level Governance Compliance Checks** *Our observations of the A&E department during our inspection found many of the issues identified continued and were not addressed. We found intravenous (IV) fluids were stored in an open corridor which was unsupervised and unlocked; vials of emergency drugs were left on countertops when they should have been stored in locked cupboards; a lack of a cleaning schedule or check list for cleaning trolleys; and equipment was visibly unclean. We also found one mattress and three hospital trolleys stained with a substance which looked like blood, inappropriate storage of dirty linen, and lack of storage space. We also saw one instance where a doctor cleaned a bowl containing blood with gauze rather than a disinfectant agent; the bowl was then left on a shelf.*	1. Associate Director of Clinical Compliance to be appointed.	Associate Director of Clinical Compliance appointed	July 2013	Director of Nursing	The results of all levels of ward inspections will be reported to the Executive Board and Trust Board on a monthly basis via the Patient Safety Report.	Recurrent revenue to employ a compliance team circa 100K
		2.Standard patient safety/ quality return to be developed which incorporates: - Care Plans; - Fire Doors; - Drug Cupboards; - Locked Drug Rooms & Access - Cleaning Schedules; - Call Bells; - Hygiene & Cleanliness etc.	Standard checklist.	July 2013	Director of Nursing	Standard checklist to be signed off by Executive Board.	Existing resource only
		3. Ward inspections: a) Each Ward Matron to use checklist to make 'daily return' on ward to Associate Director of Clinical Compliance and Lead Nurse; b) Associate Director of Clinical Compliance to review/assess ward matron returns and to take action (with the lead nurse) to fix problematic areas.	Completed checklists and summarised findings.	From July 2013	Director of Nursing	Monthly Patient Safety Report to highlight outcomes from each tier of ward inspections.	Existing resource only Existing resource only

Action ref.	Reference Within Report	Action Required	Action to Date/Evidence	Due Date	Resp.	Ongoing Assurance Processes	Resource Required
		c) The Associate Director of Clinical Compliance will ensure that a 'peer review' audit of each ward area (independent to the ward, either led by the Associate Director or a lead nurse from a different clinical area) is undertaken to verify the matron returns and to provide further assurance of action/compliance. This will scrutinise ward compliance, highlight concerns and drive forward action as a result, led by the Associate Director of Clinical Compliance. e) In addition to this, members of the Board and divisional senior management team will each, accompanied by a member of the senior nursing team, undertake a ward audit using the standard checklist each month with results being reported to the Associate Director of Clinical Compliance.					Existing resource only Existing resource only
16.7	**Governance Relating to the Escalation of Pharmacy Audits/Concerns** *There was a series of ward drugs storage audits of various wards which were undertaken*	1. *Assuming 'low risk' findings:* All pharmacy audit activity to be reported to the Trust Clinical Effectiveness Group via the Medicines Management Group, with upwards reporting to the	Reporting structure in place.	From July 2013	Director of Corporate Affairs	All non-urgent pharmacy audit activity to be reported to the Trust Clinical Effectiveness Group via the	Existing resource only

Action ref.	Reference Within Report	Action Required	Action to Date/Evidence	Due Date	Resp.	Ongoing Assurance Processes	Resource Required
	by the hospital pharmacy department. The audits we saw identified concerns, across a number of wards, about the way in which medicines were stored. During our inspection on the 7 and 8 May 2013, we found the concerns raised in the audits were not always addressed. For example an audit of ward four in February 2013, which was carried out by the trust's pharmacy department, found the drug room door was propped open by a pedal bin and that a secure key pad was needed for the drug room door. It also found that the cupboards holding medicines were not locked and that fridge temperatures were not monitored.	Healthcare Governance Committee. 2. All 'high risk' outcomes identified by audits to be escalated immediately to the Chief Operating Officer in order for urgent action to be taken.	Chief Operating Officer to report directly to Executive Board / Trust Board on urgent issues and to take appropriate action.	From July 2013	Chief Operating Officer	Medicines Management Group, with upwards reporting to the Healthcare Governance Committee. Exec/Trust Board to be directly informed by the COO.	Existing resource only

Action ref.	Reference Within Report	Action Required	Action to Date/Evidence	Due Date	Resp.	Ongoing Assurance Processes	Resource Required
16.8	**Reducing Delay of 'Necessary Decisions' to be Taken as part of Risk Mitigation** *On the AMU, MIDU, ward seven, and ward 18 staff told us, and we observed, that cabinets which were used to store patients' medication, (called "POD lockers or PODs"), were broken. Staff told us they had been broken for some time.* *The trust risk assurance framework dated 24 April 2013 stated 'Medicine storage on wards / medicine transfer with patient (Division B) also identified as a top risk – PODS broken'.*	1. Where clinical risks are identified within clinical areas, actions that cannot be immediately undertaken and require a management decision (such as relating to investment) must be *clearly distinguished* from other risks listed within the Risk Assurance Framework in order to highlight that such a decision is required.	RAF from July 2013.	From July 2013	Director of Corporate Affairs	This amendment to the RAF presentation will be seen at the Executive Board and Trust Board.	Existing resource only

Action ref.	Reference Within Report	Action Required	Action to Date/Evidence	Due Date	Resp.	Ongoing Assurance Processes	Resource Required
16.9	**Identification of 'ward-level risk'** *The trust failed to identify risks arising from the inability of patients to access call bells and delays to staff responding to call bell requests.*	1. Any persistent risk issue highlighted through the ward level compliance inspections described above which cannot be immediately resolved will be added to the relevant Division's Risk Assurance Framework, as instructed by the Associate Director of Clinical Compliance. This will ensure appropriate escalation, allowing for a decision on the risk to be made at the most appropriate level.	Divisional RAF documents will show 'source' of risk to be 'ward compliance checks'.	From July 2013	Director of Nursing	This amendment to the RAF presentation will be seen at the Executive Board and Trust Board.	Existing resource only
		2. However, any high risk to patient safety/care identified through the ward level compliance checks will be immediately escalated to the Director of Nursing by the Associate Director of Clinical Compliance to ensure urgent resolution.	Exec/Trust Board minutes, demonstrating 'urgently raised issues'.	From July 2013	Director of Nursing	The assurance for the escalation of urgent clinical risks comes through the comprehensiveness of the ward-level compliance checks described above.	Existing resource only
		3. Dedicated Chief Executive e-mail to be set-up for frontline staff to raise concerns related to the safety or quality of patient care and to share good practice.	E-Mail log documenting concerns	By end July 2013	Director of Nursing	This will be monitored by the corporate nursing team who will ensure that all e-mails get a response within 2 working days.	Existing resource only
16.10	**Quality of Clinical Documentation**	1. Comprehensive clinical documentation audit complete and	Audit Complete.	June 2013	Director of Corporate	Audit results and recommendations	Existing resource

Action ref.	Reference Within Report	Action Required	Action to Date/Evidence	Due Date	Resp.	Ongoing Assurance Processes	Resource Required
	The panel also identified concerns about the quality of case notes which was, according to the notes, being investigated through two work streams. To address the issue, a new quality of clinical documentation group was to be established by 1 April 2013. At the time of our inspection in May 2013, the group was not yet established despite poor clinical documentation being listed as one of the trust's top risks. The trust's clinical audit forward plan for April 2013-March 2014 showed a documentation audit was planned to start in quarter three of 2013-14.	reported to the Clinical Effectiveness Group, Quality of Clinical Documentation Group (QCIG) and Healthcare Governance Committee. 2. As above, QCIG now established and has met under the chairmanship of the Medical Director. QCIG to develop plan for improvement of clinical documentation, on the basis of recent documentation audit findings.	 QCIG established under agreed Terms of Reference. Plan for improvement to be submitted to Healthcare Governance Committee in September 2013.	 Implemented July 2013 September 2013	Affairs Medical Director	will be used as the benchmark against which progress in this area is measured. The clinical documentation improvement plan will be received by the Healthcare Governance Committee in September 2013.	only Existing resource only
16.11	**Incident Investigation Backlog** *However, some of the incidents we saw recorded on the trust's incident recording database were overdue for investigation and response.*	1. CEO scrutiny of incident backlog to ensure sufficient seniority of challenge. 2. DATIX usage training to be refreshed and rolled-out to all divisional staff. 3. Divisions to agree resource in order to return to a manageable, 'business as usual' situation with	Implemented. Specification of Training Plan to be Agreed. Elimination of backlog.	In place end June 2013. By end July 2013. By end July 2013.	Director of Corporate Affairs Director of Corporate Affairs Chief Operating Officer	Daily e-mail updated to the Executive. Training usefulness to be audited via feedback and improved in response. Divisional plans to be signed off by the Executive Board.	Existing resource only Existing resource only Additional divisional governance

Action ref.	Reference Within Report	Action Required	Action to Date/Evidence	Due Date	Resp.	Ongoing Assurance Processes	Resource Required
		regard to incident backlog.					support to be identified
		4. Twice-weekly reporting of Patient Safety Incidents to NRLS.	NRLS Database report to be overseen by Healthcare Governance Committee.	Implemented	Director of Corporate Affairs	Evidenced through NRLS-produced compliance reports.	Existing resource only
		5. Datix Compliance team to take on responsibility for 'Stage 1' incidents; allocation and initial grading. This will free divisional staff to focus upon incident investigation and ensure that the incident proceeds down the correct 'path' from the outset.	Reduction in number of incident reports 'breaching' timescales relevant to 'Stage 1', as evidenced in daily incident figures sent to CEO.	Implemented	Director of Corporate Affairs	Change evidenced through daily incident backlog reporting referred to above.	Existing resource only
16.12 Rep Pg 23	**Complaints** *Timeliness of complaint responses an issue. Lack of adequate follow-up of incident/complaint investigations. Complaints process to be reviewed.*	1. Complaint timeliness monitored on a monthly basis and additional resource invested in Division C to improve responsiveness. Complaint acknowledgement and response time both internal KPI measures.	Monthly complaint numbers monitoring.	Implemented.	Director of Corporate Affairs	The Board will oversee performance against these KPIs directly.	Existing resource only
		2. Each division now has a recommendations tracker which tracks the implementation of learning points arising from	Trackers established. Committee minutes will evidence review.	August 2013	Director of Corporate Affairs	Board to be informed re: outcome of Healthcare Governance Committee scrutiny.	Existing resource only

Action ref.	Reference Within Report	Action Required	Action to Date/Evidence	Due Date	Resp.	Ongoing Assurance Processes	Resource Required
		complaints and incidents. Each division will present their Tracker at the August Healthcare Governance Committee meeting and thereafter each Tracker will be scrutinised in isolation by Divisional Clinical Governance meetings and future Healthcare Governance Committee meetings. 3. Complaints & PALS Action Plan agreed and signed off at July Healthcare Governance Committee meeting. This streamlines the Trust's complaint/PALS processes, aims to improve Complaints/PALS customer service and ensures better integration with incident workstreams.	Action plan agreed. Implementation to be monitored by Healthcare Governance Committee.	All actions due for completion by Oct 2013.	Director of Corporate Affairs	Board to be informed re: outcome of Healthcare Governance Committee scrutiny.	Existing resource only
16.13 Rep 23	**Staff Raising Concerns** *Trust failed to respond to concerns identified by staff. Staff felt disempowered and unheard. Staff felt that concerns would be dismissed and/or feared reprisal associated with raising such concerns.*	1. Whistleblowing Policy to be rewritten and circulated to all staff.	Whistleblowing Policy	August 2013	Director of HR	Use of new policies to be audited within first year to gauge effectiveness with the outcomes being reported to the Board (applies to all 3 actions under this heading).	Existing resource only

Action ref.	Reference Within Report	Action Required	Action to Date/Evidence	Due Date	Resp.	Ongoing Assurance Processes	Resource Required
		2. New Clinical Concerns Policy to be written based on the work undertaken by external advisers. This is aimed at establishing a process for aggregated matters of patient safety (not falling under incident or whistleblowing categories) to be escalated and addressed appropriately.	Clinical Concerns Policy	August 2013	Medical Director		Additional resource required & agreed- InPractice team to be instructed to lead & advise on work; circa £8k.
		3. New Whistleblowing and Clinical Concerns policies to be launched with staff as part of an internal engagement campaign aimed at alleviating fears of reporting concerns.	Minutes/records/slides from launch events.	September 2013	Director of HR		Existing resource only
16.14	**Further Actions to Address Generic Governance Comments** *From the evidence above you have failed to ensure that systems in place to regularly assess and monitor the quality*	1. Commission PWC to undertake initial audit + support programme to enhance and increase resilience of Trust ward-level governance arrangements. The emphasis will need to be on the action the Trust can take in order to maintain good	Terms of Reference for work to be agreed by end July 2013.	Programme to commence August 2013.	Director of Corporate Affairs	Executive Board and Trust Board to receive Terms of Reference	Funding required, to cover cost of initial audit and follow-up support

Action ref.	Reference Within Report	Action Required	Action to Date/Evidence	Due Date	Resp.	Ongoing Assurance Processes	Resource Required
	of services provided in the carrying on of the regulated activity, enable the management of risk relating to the health, safety and welfare of service users and others who may be at risk to be managed effectively.	standards of ward-level governance within an operationally challenging environment. 2. The Executive to agree use of 'protected time' for lead nursing staff to focus upon specified quality governance issues and tasks (incidents, complaints, equipment checks, clinical audit documentation reviews etc.).	The Executive to define 'quality governance' tasks and for these to be disseminated to all lead nurses.	Tasks specified & dedicated time agreed from August 2013. Progress monitored on a monthly basis thereafter.	Director of Nursing	The outputs of the dedicated quality governance time will be monitored by the Divisional Associate Directors of Nursing and reported to the Trust Executive Board.	work; circa £120k Existing resource only
		4. The Trust will appoint a Site Manager to ensure that estate/facility related problems identified in clinical areas are addressed in a timely fashion. Such problems will be identified either through the ward-level compliance checks above, or through site audits undertaken by the Site Manager.	Appointment of Site Manager; site manager audit rota. Maintain a schedule of repair/replacement.	By August 2013	Director of Estates & Non-Clinical Services	Site Manager to maintain log of reported issues and to report on to the Risk Assurance Framework any matter which cannot be immediately resolved.	Additional resource; c.£15k in 2013/14

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OUTCOME 21: Records
CQC Judgement: Moderate Concern - The trust did not ensure that patients were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them. Patient records did not always reflect the care and treatment provided to patients. Records were not always kept securely and were not always able to be located promptly when required.

Action ref.	**Action Required & What Action Intends to Achieve**	**Measurable Outcome of Action/ Evidence Action**	**Resp.**	**Due Date**	**Resource Implication/ Cost**	**Ongoing Assurance Processes**	**Update on Progress with Actions as at *19/7/13***
21.1	Review current nursing care planning, assessment and progress recording documentation and develop a revised systematic process for assessment, care planning and documentation of care. This revised process and paperwork will be described in a documentation policy; with a system for implementation in the clinical setting through education, audit and support. This action is intended to protect patients against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them.	• Paperwork and process for planning, assessing and recording nursing care • Training programme • Records that reflect the patients care and treatment	DoN	13 Sep	N/A	• Each Ward Matron (or nurse in charge in their absence) to undertake daily quality monitoring and record on ward quality return compliance with nursing care standards (taking remedial action to make improvements if required). This return will be monitored by the Compliance team lead by the newly appointed Associate Director of Clinical Compliance and Lead Nurses. • The by the compliance team lead by the newly appointed Associate Director of Clinical Compliance will review ward matron returns and take action (with the lead nurses) to fix problematic areas that cannot or have not been remedied at ward level. • The by the compliance team lead by the newly appointed Associate	

Action ref.	Action Required & What Action Intends to Achieve	Measurable Outcome of Action/ Evidence Action	Resp.	Due Date	Resource Implication/ Cost	Ongoing Assurance Processes	Update on Progress with Actions as at *19/7/13*
						Director of Clinical Compliance will ensure that a 'peer review' audit of each ward area (independent to the ward, either led by the Associate Director or a lead nurse from a different clinical area) is undertaken to verify the matron returns and to provide further assurance of action/compliance. This will scrutinise ward compliance, highlight concerns and drive forward action as a result • In addition to this, members of the Board and divisional senior management team will each, accompanied by a member of the senior nursing team, undertake a ward audit using the standard checklist each month with results being reported to the Associate Director of Clinical Compliance.	
21.2	The Records Management Policy will be reviewed to describe the structure and process for securely storing individual patient records together from all professions on a ward. This revised process will be implemented in the clinical setting through education, audit and support. This action is intended to protect patients against the risks of unsafe or inappropriate care and treatment arising	• Updated policy • Secure collated individual records	DoN	10 Sep	N/A	• Records storage/ management will be monitored via the ward level governance compliance process described in 21.1	

Action ref.	Action Required & What Action Intends to Achieve	Measurable Outcome of Action/ Evidence Action	Resp.	Due Date	Resource Implication/ Cost	Ongoing Assurance Processes	Update on Progress with Actions as at *19/7/13*
	from a lack of proper information about them.						
21.3	It will be clarified to all staff that Real Time is not a substitute for the patient record. This action is intended to protect patients against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them.	• Communication with staff	DoN	26 July	N/A	• Records that reflect the patients care and treatment will be monitored via the ward level governance compliance process described in 21.1	
21.4	Review compliance with risk assessments aimed at the identification and appropriate management of deterioration of patients. This action is intended to protect patients against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them.	• Compliance with risk assessments and the associated actions	DoN	21 Aug	N/A	• Records that reflect the patients care and treatment will be monitored via the ward level governance compliance process described in 21.1	

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