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Date of issue: Monday, 11th September 2013

MEETING	**HEALTH SCRUTINY PANEL** (Councillors S K Dhaliwal (Chair), Chohan, Davis, Grewal, Mittal, Plimmer, Sandhu, Small and Strutton)
DATE AND TIME:	TUESDAY, 17TH SEPTEMBER, 2013 AT 6.30 PM
VENUE:	MEETING ROOM 3, CHALVEY COMMUNITY CENTRE, THE GREEN, CHALVEY, SLOUGH, SL1 2SP
DEMOCRATIC SERVICES OFFICER: **(for all enquiries)**	GREG O'BRIEN 01753 875013

SUPPLEMENTARY PAPERS

The following Papers have been added to the agenda for the above meeting:-

* Item 7 and 8 contain updated versions of the papers circulated with the agenda.

PART 1

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Heatherwood and Wexham Park Hospitals NHS
NHS Foundation Trust

Action Plans in Response to care Quality Commission Inspection in May 2013

September 2013 Update

The plans attached address the concerns raised by the Care Quality Commission. The plans are reviewed weekly by the Trust Executive Team and monthly by the Healthcare Governance Committee on behalf of the Board. The plans discussed at a number of internal forums and formally at Trust Governor meetings. In addition they are used to provide updates to Local Authority Overview and Scrutiny Committees, Clinical Commissioning Groups and Monitor (Foundation Trust Regulator). The plans can be printed and viewed in black and white but they are colour coded for additional clarity – the key is as set out below:

	Action Complete
	Action on plan for completion
	Action under review or further consideration
	Action behind plan

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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 *August 2013*	Update on Actions September 2013
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 • Work commenced 12/8/13	Work on target for completion by Mid October
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 • Work	Work on target for completion by mid October

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							commenced 12/8/13	
1.3	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, including privacy and dignity.	• Job Description • Appointment of Ward Manager	COO	30 Aug	£40k recurrent revenue	Review of A&E rota.	• Complete. . Lead Nurse A&E has identified nurse to take responsibility for leadership in EDDU.	**Action Complete**
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	**Action 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	• Gowns & additional nightwear stock levels have now increased. • Additional XL sizes now	Stock in place however not all sizes available and quality of dressing gowns is poor. Alternative sourcing underway.

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						above.	added to the Synergy contract. • Dressing gowns added to the Synergy contract	
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 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	• 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	• Existing arrangements and policies being reviewed • Draft policy to next patient reps group for discussion and comment. This group will also support the implementation plan	Draft Policy to be reviewed and considered at Quality Programme Board through September Regular ward quality rounds include asking patients if they feel they have been involved and informed of their care plan etc.

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	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	• Elective and non elective numbers modelled and being reviewed by ex Medical Director	Work on plan to present capacity Plan to Board in October
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 • Work commenced 12/8/13.	Work on target for completion mid October

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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	• A&E rota tool reviewed in light of anticipated capacity expansion to identify additional posts to be recruited to.	Additional staffing identified to meet demand and recruitment under way. Winter Pressures funding of £3.9m received by the Trust to ensure staffing to cover all identified pressures.
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	• Rapid Assessment and Treatment (RAT) for “majors patients is partly in place. A more suitable area has been identified as part of the infrastructure changes in A&E to ensure the trust is better prepared for winter 13/14.	RAT commenced in early September in advance of the building improvement.

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							Full RATing will commence on completion of A&E redevelopment.	
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 patients' individual needs.	• 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.	• In progress – meetings taking place and work with medical director to merge both documentation groups to work towards a single patient record • Care plan audit taking place and immediate action when issues are found • Care plans and other documentation checked as part of daily quality	Immediate issues addressed through regular ward quality checks. New nursing documentation ready to be implemented in October with training through September.

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						• 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	walkabouts. Standard noted to be improving • Matrons all presented at quality review panels and all report improvement in record keeping • Work continues to audit records and a 3rd report from the auditors is due. All wards will have been visited by 13th September	

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						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.		

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4.6	A review of ward management to 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.	• Review report • Improvement plan	DoN	27 Sep	£30k one off cost for review	• The improvement plan will be monitored by the trust executive.	• Additional resource in place. Working with wards in priority order. • Issues are dealt with as they emerge and a final report with action plan s due on 17th September	The review is underway and due to report to the Quality Programme Board within the defined timetable.
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.	• Ward level uptake of dementia screening monitored on daily basis. Support from the mental health team provided for wards who are struggling • Sunflower symbol rolled	Dementia training has been re-launched, however there is a need to consider the efficacy of that training. A further review of what training and who should be trained is being undertaken and will report to Quality

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							out across hospital • Training reissued and uptake monitored at ward level • Uptake good in most areas. Where areas show a low uptake, this is highlighted to the Divisional AD and the mental health team offer additional support	Programme Board at the end of September.
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.	• Dementia friendly cutlery, plates, beaker tops being sourced. • Dementia champions being identified for all areas • Dementia bay being	The Dementia bay is on plan and work is underway on the other initiatives but the Executive recognise that there needs to be improved co-ordination and delivery of the trust wide approach to

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							developed with dedicated HCA	dementia. This will be discussed in the Quality Programme Board and further actions identified.
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	• MIDU; Rehabilitation / Physiotherapy and Discharge Lounge not used as an escalation areas. • Final Draft under development for review on 23/8/13 • Interim Plan Complete and in place	The full Escalation Policy will be launched by 1 October. Interim Plan currently provides appropriate safeguards about the use of escalation beds.

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						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.		Ward 17 will open on 1 October as planned.
4.11	Provide an additional 28 beds through renovating and then establishing Ward 17 to be used as the 'first stage' escalation area within	• Plans for redevelopment • Approval of plans and	DoFa	17 Sep	£ 700k capital	• Emergency Care Pathway improvement plan and performance	• Plans and capital spend agreed by trust finance	Ward will open on 1 October as planned

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	new Surge 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.	capital spend • Project Plan • Completion of building work				report monitored by the trust executive	& business development committee • Work commenced for strip out w/c 25/7/13 • Work commenced to re-fit 8/8/13	
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.	• Additional to the normal ward checks for call bells, the Site Manager is undertaking a daily call bell check of 10% of call bells on each ward. (Policing & Audit) • The Site Manager's daily check is confirming that call bells are fully functional on most	**Action Complete**

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							occasions. As of 16/8/13 4 call bells were not fully functional and were replaced. Response time will be 0-4 hours during normal working hours (7am-9pm) and by 8am the following morning from an overnight failure. • Where repairs cannot be made immediately there will always be a temporary resolution from a call bell failure while permanent rectification is underway, and manual replacements	

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							will be provided	
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.	• Call bell system audited and replacements made where necessary • Call bell access and response times included in the daily quality walkabouts • Manual call bells available where necessary	**Action Complete**
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 to ensure that the delivery of care meet patients' individual needs.	• 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.	• In place – on roster and each nurse in charge has a badge clearly showing this	**Action Complete**

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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 • Examples of e-mails to be shared at the weekly quality board	**Action 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 August 2013	September 2013 Update
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	• Reporting structure in place and written in policy • Weekly meetings between DIPC and Head of IC in place	**Actions Complete**
8.2	The outcomes of all scheduled infection	• Audit report updates will	MD	31 July	N/A	• Monitoring of progress in responding to audits at the	• The upwards information flow	**Action Complete**

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	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.	indicate a timely response to all 'high risk' outcomes				Infection Control Committee; the Patient Safety Group; and the Healthcare Governance Committee	relating to infection control audits will be tested by the Healthcare Governance Committee.	Infection Control Committee now reports directly into Healthcare Governance committee
8.3	Establishment of new Infection Control Audit dashboard, reported to the Trust Board each month. This is intended to ensure that there is enhanced monitoring of timely actions to protect people from the risk of infection.	• Infection control dashboard received by the trust board	MD	5 Sep	N/A	• Infection control dashboard will be monitored by the trust board	• In progress	Dashboard designed and will come to October Trust Board
8.4	Commence a full deep clean of all ward areas aimed at ensuring satisfactory standards	• Recruitment to two deep clean teams • Commence	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	• Team recruited • Work commenced 29/7/13	The teams are in place. A number of areas have been completed however

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	of cleanliness can be maintained from a clear baseline. This is aimed at ensuring patients are cared for in an appropriate environment.	deep clean				below.		it is difficult accessing bed bays due to capacity. Now agreed that the team will support ward domestics to provide an enhanced clean to bays that are full.
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.	• Complete and rectification actions ongoing. • Urgent actions completed • Site Manager appointed, 6 days a week, 7th day remote by phone	**Action complete.** Audit undertaken and Site manager in place. Works commenced to ensure all audit findings are corrected with daily checks to ensure works complete
8.6	Refurbishment schedule to be reviewed and implemented,	• Review and reprioritisation of improvement	DoFa	5 Aug	Within capital programme	• Monthly capital planning group will monitor progress hospital refurbishment programme.	• £1m of capital funding was transferred to the Estates	**Action complete.** A schedule of refurbishment work has been completed

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	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.	schemes at capital planning group monthly.					Manager to cover roofing, PLACE (PEAT) improvements, ventilation, toilets, corridors and other minor schemes	and work commenced to ensure that repairs are effected. The refurbishment schedule is monitored weekly at the Quality Programme Board to ensure timely action.
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	• 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.	• A&E design provides extra store space • During Aug/Sept, ward/dept discussions to take place re providing permanent/temporary storage solutions where practically possible.	Action in progress with A&E resolution within current expansion due to open mid October.

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	risk to cleanliness and contamination.							
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 1 Oct 1 November	N/A	• Cleaning schedules to be available in every ward • Monitoring of standards of ward cleanliness to be undertaken regularly and signed off by ward matrons • Process of ensuring feedback from the monitoring of cleanliness from ward to Board to be in place.	• Cleaning schedules disseminated to all relevant areas and on wards displayed in sluice room, cleaning trolley and nurse station. • Cleaning schedules jointly monitored by Matrons and Domestic Supervisor	Cleaning schedules are now available on every ward The process for joint monitoring between Domestic Supervisor and Matron will be agreed during September and commence in October Board reporting will commence on 1 November.
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.	• Re-launch of Helpdesk, process started 9/8/13. • On-going communication underway	**Action Complete**, facilities Helpdesk service now available 24 hours a day, 7 days per week. Survey of customer satisfaction with the new arrangements to be undertaken in this month.

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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 infection.	• Improved compliance with hand hygiene standards	MD	2 Aug	N/A	• Monitoring of progress in responding to audits at the Infection Control Committee; the Patient Safety Group; and the Healthcare Governance Committee.	• Training being undertaken and process in place to support/ address areas of low compliance.	**Action Complete** Improved Infection Control signage will also be put in place over the next 2 months

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.

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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.	• Audit completed • Where deficiencies identified have been rectified • Further improvement action identified and completed by 19/8/13	**Action Complete**
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	• 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	• Audited through regular recorded ward quality rounds.	• Audit of ward fridges completed – repairs and replacements made where necessary • Additional stock ordered to enable	**Action Complete**

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 August 2013	Update on Progress September 2013
	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.						swift replacement if needed • Checked as part of the ward matron quality check and quality walkabout	
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 the unsafe storage of medicines.	• Clear communication of expectations to all nurses.	DoN	26 July	N/A	• Audited through regular recorded ward quality rounds	• Complete – reiterated at bed meetings on several occasions • Checked as part of the ward matrons daily quality check and the quality walkabouts	**Action Complete**
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	• Clear communication of expectations to all nurses. • Attendance at refresher training as required.	DoN	26 July	N/A	• Audited through regular recorded ward quality rounds	• Complete – message sent with the Trust policy, NMC standards and NMC Code of Conduct	**Action Complete**

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 August 2013	Update on Progress September 2013
	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.						• Adherence to Code of Conduct and other NMC Standards reiterated at bed meeting. • Some areas have laminated and display the standards	
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.	• In progress. Some SOPs written and others being developed • Some SOPs covered by the medicines management policy. The remainder are out for comment and will be finalised	There remain a few SOPs to review. This is expected to be completed by the end of September

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 August 2013	Update on Progress September 2013
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	• Refreshed nursing staff baseline and process for daily flexibility	DoN	2 Aug	N/A	• Trust executive and trust board will monitor staffing metrics monthly.	• Date changed to 31 Aug approved to facilitate complete process • Safer Nursing Tool being used across the wards • Data collection finished on 19th August • All data collected and analysis in progress	Awaiting final analysis due 20 September. Delay due to the need for data collection to be over an extended period to ensure accuracy.

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 August 2013	Update on Progress September 2013
	employed to provide care and treatment to patients.							
13.2	From this review a 'best practice' ward establishment template for each ward which incorporates an 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.	• Baseline staffing requirements. Describe by ward.	DoN	9 Aug	N/A	• Trust executive and trust board will monitor staffing metrics monthly	• Awaiting analysis	Awaiting analysis, action reviewed by Executive and will now be completed by mid October
13.3	Enhance direct nursing leadership/management on the Emergency Department Decision Unit	• Job Description • Appointment of Ward Manager	COO	30 Aug	£40k recurrent revenue	• .Evidence in staffing rota	Complete with a Band 6 Nurse now in place in charge of EDDU	**Action Complete**

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 August 2013	Update on Progress September 2013
	(EDDU) by appointing a dedicated Junior Ward Manager; who will be responsible for ensuring standards of nursing care are maintained and directly supervised.							
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. • Final Draft under development for review at end of August • Interim Plan Complete and in place	The interim escalation plan is in place. Use of any escalation area agreed/approved by Director on call and signed off on daily report sheet. Full Escalation Policy out for final comments to be completed and approved by Executive at the end of Sepetmber

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 August 2013	Update on Progress September 2013
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 meet patient's needs.	• Recruitment plan	DoHR	24 Sep	Within current plans	• Trust executive and trust board will monitor staffing metrics monthly.	• Review of current plans and areas for development being undertaken • Additional resource started on 22nd August) identified to ensure deadline met.	Active recruitment on-going. Review of NHSP pay rates to be concluded by mid September to determine whether Trust needs to increase rate to ensure competitive against Agency rates.
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	• Elective and non elective numbers modelled being reviewed by ex Medical Director	Capacity Plan will be finalised and discussed at Trust Board in October.
13.7	To review the current	• Retention and engagement	DoHR	24	Plan is likely	• Trust	• Review of	Plan will be

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 August 2013	Update on Progress September 2013
	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.	strategy • Implementation actions		Sep	to need resourcing	executive and trust board will monitor staffing metrics monthly.	current plans and areas for development being undertaken • Additional resource, started on 22nd August) identified to ensure deadline met.	developed within timetable.
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 ensure appropriate clinical skill mix based on acuity is maintained.	• Clinical rota policy • Rotas with appropriate planned staffing	COO	10 Sep	N/A	• Trust executive and trust board will monitor staffing metrics monthly.	• Complete	**Action Complete**

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	September 2013 Update
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. 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 is now in place and can be evidenced through the minutes of the July 2013 Executive Board.	From July 2013 Executive Board	Director of Corporate Affairs/ Chief Executive	Evidence of risk mitigation.	Existing resource only	**Action Complete**
		2. Each Division/Directorate	'Refresh' meetings held with all Divisional/	By 26 July 2013	Director of Corporate Affairs	Refreshed RAF to be received by July Audit Committee and	Existing resource only	**Action Complete**

Action ref.	Reference Within Report	Action Required	Action to Date/Evidence	Due Date	Resp.	Ongoing Assurance Processes	Resource Required	September 2013 Update
		Risk Assurance Framework document will be refreshed during July 2013, ensuring that the RAF as a whole remains up-to-date, relevant and truly reflective of organisational risk.	Directorate leads. New document to be submitted to July Audit Committee- this is Complete.			Executive Board and August Trust Board.		
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*	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	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 Complete** Interim Plan in place, full plan due by end of September

Action ref.	Reference Within Report	Action Required	Action to Date/Evidence	Due Date	Resp.	Ongoing Assurance Processes	Resource Required	September 2013 Update
	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."	- 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 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	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	**Action Complete**

Action ref.	Reference Within Report	Action Required	Action to Date/Evidence	Due Date	Resp.	Ongoing Assurance Processes	Resource Required	September 2013 Update
		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.	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	**Action Complete**
		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. 5. There are plans to develop and then establish Ward 17 to be used as the 'first stage' escalation area; this will provide a far more	Ward 17 to be tested through Escalation Usage Protocol.	By end September 2013	Director of Estates & Non-Clinical Services	Progress in development of Ward 17 to be reported directly to the Board.	£700k Capital funding allocated	Ward 17 on plan to be open 1 October

Action ref.	Reference Within Report	Action Required	Action to Date/Evidence	Due Date	Resp.	Ongoing Assurance Processes	Resource Required	September 2013 Update
		suitable environment for patients in the event that additional temporary capacity is required.						
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 through the Infection Control Committee to the Patient Safety Group, with upwards reporting to the Healthcare Governance Committee, a Committee of the Board. 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	**Action Completed** **Action Completed and written into Policy**

Action ref.	Reference Within Report	Action Required	Action to Date/Evidence	Due Date	Resp.	Ongoing Assurance Processes	Resource Required	September 2013 Update
16.4	**Clinical Stock Shortages** *Other reports from the infection control team dated 22 and 29 April 2013 identify on-going concerns about shortages of stock and medical supplies, bed linen*.	1. Rewrite and circulate process for the raising of urgent concerns with regard to basic clinical stock.	Urgent stock request form to be developed. 24/7 Helpdesk facility available. Re-launch commenced 9/9/13. Site Manager available 7 days per week to progress urgent issues.	From August 2013	Director of Estates & Non-Clinical Services	Estates & Facilities team to keep a log of urgent ward requests and to have responsiveness reviewed as an internal KPI, reported through the Operational Performance Report.	Existing resource only	**Action Completed** staff satisfaction survey to be undertaken at the end of September
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. 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.	Reporting structure in place. Director of Estates & Non-Clinical Services to report directly to Executive Board / Trust Board on urgent issues and to take appropriate action. Revised escalation process implemented and	From July 2013 From July 2013	Director of Corporate Affairs Director of Estates & Non-Clinical Services	The Business Safety Committee will review non-urgent fire audit findings and upwards report to the Healthcare Governance Committee. 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 Existing resource only	**Action Completed** **Action Completed**

Action ref.	Reference Within Report	Action Required	Action to Date/Evidence	Due Date	Resp.	Ongoing Assurance Processes	Resource Required	September 2013 Update
			issued to wards & depts.					
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,; a lack of a cleaning schedule or check list for*	1. Associate Director of Clinical Compliance to be appointed. 2.Standard patient safety/ quality return to be developed which incorporates: - Care Plans; - Fire Doors; - Drug Cupboards; - Locked Drug Rooms & Access	Associate Director of Clinical Compliance appointed Standard checklist.	July 2013 July 2013	Director of Nursing 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. Standard checklist to be signed off by Executive Board.	Recurrent revenue to employ a compliance team circa 100K Existing resource only	**Action Completed** **Action Completed and regular checks being undertaken**

Action ref.	Reference Within Report	Action Required	Action to Date/Evidence	Due Date	Resp.	Ongoing Assurance Processes	Resource Required	September 2013 Update
	cleaning trolleys; and equipment was visibly unclean.	- Cleaning Schedules; - Call Bells; - Hygiene & Cleanliness etc.	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	**Action Completed**
		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;					Existing resource only	**Action Completed**
		b) Associate Director of Clinical Compliance to review/assess ward matron returns and to take action (with the lead nurse) to fix problematic areas.					Existing resource only	Due to commence in October
		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						

Action ref.	Reference Within Report	Action Required	Action to Date/Evidence	Due Date	Resp.	Ongoing Assurance Processes	Resource Required	September 2013 Update
		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.						Due to commence in October
16.7	**Governance Relating to the Escalation of Pharmacy Audits/Concerns** *There was a series of*	1. *Assuming 'low risk' findings:* All pharmacy audit activity to be reported to the Trust Clinical Effectiveness Group via 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 Medicines	Existing resource only	**Action Completed**

Action ref.	Reference Within Report	Action Required	Action to Date/Evidence	Due Date	Resp.	Ongoing Assurance Processes	Resource Required	September 2013 Update
	ward drugs storage audits of various wards which were undertaken 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.	Medicines Management Group, with upwards reporting to the 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.	COO to report directly to Executive Board / Trust Board on urgent issues and to take appropriate action.	From July 2013	Chief Operating Officer	Management Group, with upwards reporting to the Healthcare Governance Committee. Exec/Trust Board to be directly informed by the COO.	Existing resource only	**Action Completed**

Action ref.	Reference Within Report	Action Required	Action to Date/Evidence	Due Date	Resp.	Ongoing Assurance Processes	Resource Required	September 2013 Update
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- Complete.	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 Completed**
16.9	**Identification of 'ward-level risk'** *The trust failed to identify risks arising*	1. Any persistent risk issue highlighted through the ward level compliance inspections	Divisional RAF documents will show 'source' of risk to be 'ward compliance	From July 2013	Director of Nursing	This amendment to the RAF presentation will be seen at the Executive Board and	Existing resource only	**Action Complete**

Action ref.	Reference Within Report	Action Required	Action to Date/Evidence	Due Date	Resp.	Ongoing Assurance Processes	Resource Required	September 2013 Update
	from the inability of patients to access call bells and delays to staff responding to call bell requests.	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. 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. 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	checks'. Exec/Trust Board minutes, demonstrating 'urgently raised issues'. E-Mail log documenting concerns	From July 2013 By end July 2013	Director of Nursing Director of Nursing	Trust Board. The assurance for the escalation of urgent clinical risks comes through the comprehensiveness of the ward-level compliance checks described above. 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 Existing resource only	**Action Complete** **Action Complete**

Action ref.	Reference Within Report	Action Required	Action to Date/Evidence	Due Date	Resp.	Ongoing Assurance Processes	Resource Required	September 2013 Update
		practice.						
16.10	**Quality of Clinical Documentation** *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.*	1. Comprehensive clinical documentation audit complete and 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.	Audit Complete. QCIG established under agreed Terms of Reference.	June 2013 September 2013	Director of Corporate Affairs Medical Director	Audit results and recommendations will be used as the benchmark against which progress in this area is measured.	Existing resource only Existing resource only	Under review. Nursing documentation has been addressed through audit of current paperwork and the development and plan to introduce new Nursing paperwork at the end of September. Medical staff have been reminded of their individual responsibility to write comprehensive, clear records appropriately signed. However, the Executive are reviewing the issues regarding a new record system given potential plans with FPH

Action ref.	Reference Within Report	Action Required	Action to Date/Evidence	Due Date	Resp.	Ongoing Assurance Processes	Resource Required	September 2013 Update
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 regard to incident backlog. 4. Twice-weekly reporting of Patient Safety Incidents to NRLS.	Implemented. Datix team have written guidance on incident compliance and deliver induction, ad hoc training and 121 training where needed. Elimination of backlog. NRLS Database report to be overseen by Healthcare Governance Committee.	In place end June 2013. By end July 2013. By end July 2013. Implemented	Director of Corporate Affairs Director of Corporate Affairs Chief Operating Officer Director of Corporate Affairs Director of Corporate	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. Evidenced through NRLS-produced compliance reports.	Existing resource only Existing resource only Additional divisional governance support identified Existing resource only	Actions all undertaken; however backlog remains: Backlog in Division C has improved in the last week but Division A now has increased. The action to manage and control this matter remains corrective and a sustainable solution is still to be designed.

Action ref.	Reference Within Report	Action Required	Action to Date/Evidence	Due Date	Resp.	Ongoing Assurance Processes	Resource Required	September 2013 Update
		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	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	Action Completed, however timeliness of investigation remains an issue within Division C with a sustainable solution to be found.
		2. Each division now has a recommendations tracker which tracks the implementation of	Trackers established. Committee minutes will evidence review. However, the	August 2013	Director of Corporate Affairs	Board to be informed re: outcome of Healthcare Governance Committee scrutiny.	Existing resource only	Developing the tracker tool requires the incident and complaint backlog to have been

Action ref.	Reference Within Report	Action Required	Action to Date/Evidence	Due Date	Resp.	Ongoing Assurance Processes	Resource Required	September 2013 Update
		learning points arising from 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.	standard and level of maintenance of the Trackers needs to improve. 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	addressed for the validity of the data to be robust. Therefore this action will now move to November 2013. **Action Completed**
16.13 Rep	**Staff Raising Concerns**	1. New Raising Concerns Policy to be	Raising Concerns Policy	August 2013	Director of HR	Use of new policies to be audited within first	Additional resource	A new Raising Concerns Policy that

Action ref.	Reference Within Report	Action Required	Action to Date/Evidence	Due Date	Resp.	Ongoing Assurance Processes	Resource Required	September 2013 Update
23	*Trust failed to respond to concerns identified by staff.*	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.				year to gauge effectiveness with the outcomes being reported to the Board (applies to all 3 actions under this heading).	required & agreed- InPractice team to be instructed to lead & advise on work; circa £8k.	will incorporate the new CEO email address and will be developed through September and October. The plan is to launch 1 November.
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 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.*	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 standards of ward-level governance within an operationally challenging environment.	Terms of Reference for work to be agreed by end July 2013- Complete and work commenced. The Executive to define 'quality governance' tasks and for these to be disseminated to all lead nurses.	Programme to commence August 2013. Tasks specified & dedicated time agreed from August 2013. Progress monitored on	Director of Corporate Affairs Director of Nursing	Executive Board and Trust Board to receive Terms of Reference The outputs of the dedicated quality governance time will be monitored by the Divisional Associate Directors of Nursing and reported to the	Funding required, to cover cost of initial audit and follow-up support work; circa £120k Additional resource; c.£15k in 2013/14	Action Complete and Findings presented to September Board meeting. Recommendations will be cross referenced with action within the CQC action plans and included in the Single Quality Plan due to be presented to board in November. The review of roles and responsibilities

Action ref.	Reference Within Report	Action Required	Action to Date/Evidence	Due Date	Resp.	Ongoing Assurance Processes	Resource Required	September 2013 Update
		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.). 3. 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. Appointments complete. 6 days per week on site & 7th day by phone.	a monthly basis thereafter. By August 2013	Director of Estates & Non-Clinical Services	Trust Executive Board. Site Manager to maintain log of reported issues and to report on to the Risk Assurance Framework any matter which cannot be immediately resolved.		of Nurses is due to commence in October. Early discussions on Clinical leadership have taken place including the Medical Director and Clinical Chairs. Any new arrangements are anticipated to be implemented from November onwards. **Action complete** and site manager in place.

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 August 2013	Update on Actions September 2013
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	• In progress – meetings taking place and work with medical director to merge both documentation groups to work towards a single patient record • Care plan audit taking place and immediate action when issues are found • Care plans and other documentation checked as part of daily	Regular ward quality rounds continue to ensure compliance with current Policies for Nurse documentation. New documentation has been agreed and will be implemented by 1 October with staff training starting mid September. All wards will have old stationary removed to ensure compliance with new documentation and Policy.

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 August 2013	Update on Actions September 2013
						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	quality walkabouts. Standard noted to be improving • Matrons all presented at quality review panels and all report improvement in record keeping • Care plan audit continues and all wards will have been visited by the end of the audit • Additional sections being made available in notes to record patients views and comments	

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 August 2013	Update on Actions September 2013
						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 from a lack of proper information about them.	• 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	• Policy in draft	Policy complete and will be launched through training described above.
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.	• Communicati on 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	• Complete	**Action Complete**

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 August 2013	Update on Actions September 2013
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	• In progress – meetings taking place and work with medical director to merge both documentation groups to work towards a single patient record • Care plan audit taking place and immediate action when issues are found. Risk assessments considered as part of this and audit ensures that issues identified as part of the risk assessment are carried forward into care plans • Care plans and other documentation	**Action Complete**

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 August 2013	Update on Actions September 2013
							checked as part of daily quality walkabouts. Standard noted to be improving • Matrons all presented at quality review panels and all report improvement in record keeping	

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SLOUGH BOROUGH COUNCIL

REPORT TO: Health Scrutiny Panel **DATE:** 17 September 2013

CONTACT OFFICER: Sarah Forsyth – Scrutiny Officer
(For all Enquiries) (01753) 875657

WARDS: All

PART I

TO NOTE

HEALTH SCRUTINY – 2013/14 WORK PROGRAMME

1. **Purpose of Report**

1.1 For Members to review the current work programme for the Panel.

2. **Recommendations/Proposed Action**

2.1 That the Panel note its current work programme for the 2013/14 municipal year.

3. **Joint Slough Wellbeing Strategy Priorities**

- **Health and Wellbeing**

3.1 The Council's decision-making, and the effective scrutiny of it, underpins the delivery of all the Joint Slough Wellbeing Strategy priorities; however the Health Scrutiny Panel holds a specific remit to scrutinise and provide public transparency for health and wellbeing issues across Slough.

4. **Supporting Information**

4.1 The current work programme is based on the discussions of the Panel at its previous meetings, looking at requests for consideration of issues from officers and issues that have been brought to the attention of Members outside of the Panel's meetings.

4.2 The work programme is a flexible document which will be continually open to review throughout the municipal year.

5. **Conclusion**

5.1 The Health Scrutiny Panel plays a key role in ensuring the transparency and accountability of healthcare provision in the Borough.

5.2 This report is intended to provide the Panel with the opportunity to review its upcoming work programme and make any amendments it feels are required.

6. Appendices Attached

A - Work Programme for 2013/14 Municipal Year

7. Background Papers

None.

HEALTH SCRUTINY PANEL
WORK PROGRAMME 2013/14

Meeting Date
21 November 2013
Scrutiny Items • Dementia Care Strategy (Alan Sinclair) • A&E Review Report (A&E Task and Finish Group) • Public Health Strategy (Angela Snowling) **For Information (not for discussion. Should further discussion be required, to be added to future agenda)** • JSNA (Angela Snowling)
13 January 2014
Scrutiny Items • Slough's Management of Transition (Alan Sinclair) • Autism Strategy (Alan Sinclair) • Mental Health In-patient Services Transfer (David Townsend/Karen Watkins) • Public Health Commissioning Strategy (Angela Snowling)
24 March 2014
Scrutiny Items • Heatherwood and Wexham Park Hospitals NHS Foundation Trust Quality Account 2013/14 (HWPT) • Berkshire Healthcare NHS Foundation Trust Quality Account 2013/14 (BHFT) • Shaping the Future: implementation of changes and impact (CCG)

Currently Un-programmed:

- Vascular Services – full details of proposals (David Williams/CCG)
- Drug and Alcohol Misuse (Julia Wales/Public Health/CCG/SSP)
- Carers Strategy (Sally Kitson)
- Healthwatch (Healthwatch)
- Diabetes Strategy (Angela Snowling)
- LD Change Programme
- Francis Inquiry – Impact of findings on scrutiny (Sarah Forsyth) – information only item