James Paget University Hospitals NHS
NHS Foundation Trust

TRUST ACTION PLAN FOLLOWING ANNOUNCED CQC INSPECTION AUGUST 2015

Dated: 08/12/2015
Version: 5.01

Aim: The aim of this action plan is to ensure that CQC Requirement Notices are fully met
Content: This action plan captures all of the requirement notices from the report issued by the CQC in November 2015 and includes responsibilities and timescales for delivery.
Responsibility for delivery: Nominated Executive Leads reporting to identified governance committees

Governance: The Trust will monitor delivery of this action plan by assigning clear responsibilities and timescales to each action. Each Core Service has been assigned an Executive lead who will have oversight of the plan to ensure delivery to timescale.
The plan will be updated at least monthly and will be presented to the Patient Safety and Effectiveness Committee (Executive Committee). On a bi-monthly basis the Safety and Quality Governance Committee (committee of the Board) will receive a progress report.

Key for RAGBW rating of Actions:

(**W**)hite = Not yet started	(**G**)reen = Completed	(**A**)mber = In progress	(**R**)ed = Due but not complete	(**B**)lue = Ongoing monitoring to be assured of continued achievement

ID	Ref in Report	Issue Raised in Final Report	Action	Operational lead	Timescale	BARRIERS TO ACHIEVEMENT/PROGRESS UPDATES
Requirement Notices						
1	20	Regulation 15 (1)(a)(c)(e) The provider was failing to ensure equipment; including emergency equipment was properly checked. **Executive Lead: Director of Governance**	Inform all senior nurses and departmental managers of the immediate requirement to abide by checking procedures Take proportionate action if practice does not meet the required standard in any service	Lead Nurses/ Head of Midwifery/Service Managers	30/11/2015	

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1.1			Ensure all routine equipment maintenance schedules are fully met for all equipment.	Head of Estates	01/02/2016	The Estates Department maintains a schedule for maintaining equipment according to a prioritisation regime. The schedule is monitored and has been met since 2015.
1.2			Routinely monitor compliance to safety systems through internal governance processes	Lead Nurses/Head of Midwifery Service Managers/Head of Estates	31/12/2015	100216 Divisions reported their actions back to the PSEC Extraordinary meeting.
1.3			Provide monthly update reports to Patient Safety and Effectiveness Committee to confirm that the risks are being controlled	Lead Nurses/Head of Midwifery/Service Managers	PSEC Dates ~~05/01/2016~~ ~~02/02/2016~~ ~~08/03/2016~~ 05/04/2016 10/05/2016 07/06/2016	January meeting did not take place 100216 At the February meeting of PSEC it was decided that a series of Extraordinary Meetings would take place on a fortnightly schedule to allow sufficient time to focus on the progress to actions for CQC improvement. An action log will be the evidence for this. 140316 Process of reviewing progress at the EPSEC is working. Updated copy of this plan to be sent to PSEC for information and audit purposes.

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1.31			Provide monthly update reports of safety checks to Health and Safety Committees to confirm that the risks are being controlled 100216 After discussion at the PSEC meeting, it was agreed that further work was required to ensure that the H&S Committee was fully sighted on any risks/issues re planned maintenance of safety equipment/medical devices. Head of Clinical Audit and Compliance to contact to help resolve with Head of Risk and Safety.	Head of Estates	H&S Committee dates ~~04/01/2016~~ 04/03/2016 05/06/2016 01/07/2016	January meeting did not take place The reports to H&S Committee are not yet comprehensive. New Action 100216 140316 Copy of Premises Assurance Model has been provided and this provides documentary evidence of our governance arrangements for Medical Gases and Medical Devices. EPSEC is asked to confirm that the corporate element of this outcome is achieved.
1.4			Divisions to instigate accountability processes which require those responsible to evidence that all checks are taking place and are adequate.	Lead Nurses/Head of Midwifery/Service Managers	30/11/2015	100216 Divisions reported their actions back to the PSEC Extraordinary meeting.
1.5	20	The provider failed to ensure in theatres that the environment was properly maintained.	Review plans for phase 2 and provide documented assurance that the intended works will address the environmental risks	Deputy Director of Operations/ Theatre Manager	31/12/2015	Confirm completeness May 2016

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		Executive Lead:- Director of Finance	identified in the report.			
1.6			Provide monthly update reports to Health and Safety Committee to confirm that the risks in Theatres are being controlled. <u>100216</u> After discussion at the PSEC meeting, it was agreed that further work was required to ensure that the H&S Committee was fully sighted on any risks/issues re planned maintenance of safety equipment/medical devices. Head of Clinical Audit and Compliance to contact to help resolve with Head of Risk and Safety.	Divisional Manager Elective/ Head of Estates	<u>H&S Committee dates</u> ~~04/01/2016~~ 04/03/2016 05/06/2016 01/07/2016	January meeting did not take place. Review in March. 140316 Evidence seen in Surgery Action plan that the theatres project will deliver the require outcome. <u>EPSEC request to close</u>.
2	20	Regulation 17 (1)(2)(c) The provider was failing to ensure that each service user had an accurate, complete and contemporaneous record of their care. **Executive Lead: Director of Nursing and Workforce**	Issue a one page briefing applicable to all professional groups to remind them of the record keeping standards they must adhere to.	All professional leads (including doctors)	31/12/2015	Draft sent for comments 17.12.15 Distributed 21.12.15

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2.1			Identify and make amendments to some nursing record templates to assist compliance to record keeping standards	Lead Nurses/ Head of Midwifery	31/01/2016 11/03/2016	The Essentials of Care booklet is being reviewed using a collaborative approach which will include reference to Record Keeping Standards. First print draft expected by end of February,
2.2		Do Not Attempt Cardio Pulmonary Resuscitation Forms were found to be incomplete and decision making not of consistent quality. **Executive Lead: Medical Director**	Ensure that all Do Not Attempt Cardio Pulmonary Resuscitation forms are completed fully and in line with national guidance.	Divisional Directors	30/06/2016	The Resuscitation Committee has issued instruction to mandate clinicians to contact relatives to discuss decision making. Our current documentation needs to be amended to reflect this and we expect this to be in place by April 2016. 100216 Discussed at PSEC EM. Agreed that the issue is best resolved by enabling Trust implementation of revised national plan which will provide revised documentation, improving compliance and outcomes. 150316 EOLCG escalating concern re achievement of this action. EPSEC to discuss 290316
2.3			Medical Director to write to all doctors to require them to improve compliance to standard	Divisional Directors	31/12/2015	Draft sent for comments 17.12.15 Distribution 21.12.15

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			with immediate effect and Clinical Directors/ Consultants to enforce			
2.4			Audit DNACPR forms and report by Consultant so as to provide rapid feedback on performance	Clinical Director/End of Life Lead Clinical Audit Team/ Resuscitation Officer	31/01/2016	October audit completed. New plan to re-audit February March to measure the impact of distribution of staff Guidance Booklet
2.5		Staff on some wards were not clear on guidance they would use or actions they should take, if they were unclear whether a patient had capacity to consent. **Executive Lead: Medical Director**	Assure application of the assessment under the Mental Capacity Act 2005 at all stages but particularly end of life, by:	Divisional Directors	30/06/2016	Cross reference with EOLC and Safeguarding Action Plans
2.6			Undertaking a review of knowledge and skills of medical staff of the MCA 2005	Divisional Directors	~~31/01/2016~~ revised to 31/04/2016	Cross reference with EOLC and Safeguarding Action Plans 100216 Head of Clinical Audit and Compliance to contact Dr Lams for evidence of training. 170216 email sent to request/JS 23/02/2016 Dr Lams has responded. Also, the Adult Safeguarding Lead updated the EPSEC with detail that a rapid audit tool has been devised and will be implemented – results to follow. Revise timeline to 31/4/2016
2.7			Providing training and/or information updates as required	Divisional Directors	28/02/2016	Cross reference with EOLC and Safeguarding Action Plans
2.8			Auditing medical records after improvement actions embedded.	Divisional Directors	01/04/2016	Cross reference with EOLC and Safeguarding Action Plans

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						140316 See 2.6
2.9		The provider had failed to ensure a consistent approach to end of life care pathway. **Executive Lead: Director of Nursing and Workforce**	Appoint senior medical and nursing leadership for end of life care to advise, support and supervise the acceleration of the roll out of the end of life care plan system and advice and enforce standards of practise for end of life decision making and record keeping.	Director of Nursing and Workforce/ Medical Director	31/01/2016	Cross reference with EOLC and Safeguarding Action Plans Update Jan 2016 Clinical Educator now in place Job description for clinical lead in place recruitment process commenced for secondment (2/52 closing date) Senior nurse discussions re portfolio change due to be completed end January Roll out plan revised and accelerated (monitored through CAEOL group)
2.10			Revise EOLC Action plan to ensure alignment with the gaps identified in the report.	Director of Nursing and Workforce	30/11/2015	Cross reference with EOLC and Safeguarding Action Plans
2.11			Accelerate the implementation of the approved replacement for the Liverpool Care Pathway for people receiving end of life care	Clinical Educator End of Life Care	31/03/2016	14/12/16 Monitored by EOLC Group. Minutes meeting December as evidence of discussion
2.12			Draft an audit programme which will identify key audits as a priority. The results will be reported widely to maximise learning.	SPCT Team and Senior Clinical Audit Facilitator	31/12/2015	31/12/15 Received and awaiting Divisional Sign Off. 150316 CAEOL Group received a report confirming that Care of the Dying Audit has commenced and the

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						SPCT phone line audit has a revised start date of 220316